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ABSTRACT

The leader's manual for the curriculum guide is designed to help multidisciplinary, multiagency, or single agency groups understand and organize effective community action against child abuse and neglect. Goals; objectives; rationale; equipment, space and staff requirements; teaching reminders; and titles of resource materials are listed for each of eight units: understanding child abuse and neglect, physical abuse of children, child neglect, emotional maltreatment of children, child sexual abuse, child protective intervention, the role of the courts in child abuse and neglect, and community planning and coordination to prevent and treat child abuse and neglect. Each unit also includes detailed activity suggestions, role play profiles and instructions, and scripts for filmstrips. (CL)

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Leader's Manual

U.S. DEPARTMENT OF HEALTH,
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A CURRICULUM ON CHILD ABUSE AND NEGLECT

A Curriculum On The Identification, Reporting, Referral and Case Management of Child Abuse and Neglect

We Can Help...

EC 132884

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Leader's Manual

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of Human Development Services
Administration for Children, Youth and Families
Children's Bureau
National Center on Child Abuse and Neglect

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TABLE OF CONTENTS

PART I. 5

PREFACE 7

INTRODUCTION TO THE LEADER'S MANUAL 9

UNIT 1: 31
Introduction: Understanding Child Abuse and Neglect

UNIT 2: 71
Physical Abuse of Children

UNIT 3: 107
Child Neglect

UNIT 4: 133
Emotional Maltreatment of Children

UNIT 5: 147
Child Sexual Abuse

UNIT 6: 183
Child Protective Intervention

UNIT 7: 229
The Role of the Courts in Child Abuse and Neglect

UNIT 8: 261
Community Planning and Coordination to Prevent and Treat Child ABuse and Neglect

PART II. 287

Child Abuse and Neglect: Building Skills in Dealing with Families 289

Part I

PREFACE

The Child Abuse Prevention and Treatment Act (P.L. 93–247, as amended) charges the National Center on Child Abuse and Neglect to "compile, publish and disseminate training materials for personnel who are engaged or intend to engage in the prevention, identification, and treatment of child abuse and neglect . . ." (Section 2(b)(3)).

To fulfill this legislative mandate, the National Center began the development of the WE CAN HELP curriculum in 1974, working through contracts with the Urban and Rural Systems Associates (URSA) of San Francisco and META/4 of Los Angeles. The extensive multimedia product of USRA's and META/4's efforts was completed in October 1976. It was composed of a 12-unit "core" curriculum for multidisciplinary audiences and specialized units for social workers, health and medical professionals, educators and law enforcement professionals. During the following 12 months, this first edition of WE CAN HELP formed the basis for the National Center's demonstration training grants program, with 16 State public agencies and six national professional membership associations. All or parts of the curriculum were used to provide training for over 23,000 participants.

Following the evaluated experience of the 22 demonstration training projects, the National Center revised and expanded the WE CAN HELP curriculum. Its components now include:

- The basic curriculum on child abuse and neglect,
- Building skills in dealing with families,
- Specialized training for child protective workers, and
- Specialized training for educators.

Additional components of WE CAN HELP which are in the process of revision or development are:

- Specialized training for law enforcement professionals,
- Specialized training for medical professionals,
- Specialized training for court personnel, and
- Specialized training for public health nurses.

The National Center's responsibility in the area of training is only partially addressed by the development and dissemination of WE CAN HELP. Through the network of Regional Child Abuse and Neglect Resource Centers, the National Center seeks to assist in the establishment of ongoing preservice and inservice training programs for all those who have roles in combatting child abuse and neglect. The curriculum materials contained in this volume and in the companion volumes and audiovisual materials that make up WE CAN HELP are meant to serve as tools for community efforts to prevent and treat child abuse and neglect more effectively.

INTRODUCTION TO THE LEADER'S MANUAL

James A. Harrell
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I. OVERVIEW OF THE CURRICULUM

WE CAN HELP: A Curriculum on Child Abuse and Neglect is a basic curriculum for multidisciplinary and multiagency groups. It may also be used for single-agency preservice or inservice training and with citizen advocates to develop the understanding necessary to organize effective community action against child abuse and neglect.

An underlying purpose of this curriculum is to support the development of knowledgeable community child protective networks -- ones that incorporate relevant public and private agencies from the fields of social service, education, health, law enforcement and mental health and are supported by informed citizen advocacy. To address this purpose, the basic curriculum contains these units:

- Unit 1—Introduction: Understanding Child Abuse and Neglect (3 hours 35 minutes)
- Unit 2—Physical Abuse of Children (3 hours 40 minutes)
- Unit 3—Child Neglect (3 hours)
- Unit 4—Emotional Maltreatment of Children (2 hours)
- Unit 5—Child Sexual Abuse (2 hours 15 minutes)
- Unit 6—Child Protective Intervention (4 hours 40 minutes)
- Unit 7—The Role of the Courts in Child Abuse and Neglect (1 hour 30 minutes)
- Unit 8—Community Planning and Coordination to Prevent and Treat Child Abuse and Neglect (3 hours 20 minutes)

The materials which form the curriculum are (1) the Leader's Manual; (2) **WE CAN HELP Resource Materials**—reading materials for participants; and (3) audiovisual materials, including seven filmstrips/cassette recordings and six 16 mm. films.

II. FORMAT OF THE CURRICULUM

Each unit in this curriculum provides leaders with the information, directions and materials they need to conduct the unit.

The information presented in the first pages of each unit includes:

- A brief, one-paragraph description of the unit;
- The goals of the unit—what the unit is meant to convey and why;
- The objectives of the unit—minimal standards for what participants are expected to learn from the unit;
- The rationale (or philosophy) of the unit;
- The activities of the unit, with time estimates and required materials;
- Additional staff needed to present the unit;
- Space requirements to present the unit;
- Equipment requirements of the unit;
- Audiovisuals needed for the unit;
- "Before You Begin" reminders for the unit; and
- Participants' materials required for the unit.

Following these general descriptions and directions, each unit provides an activity-by-activity "text" for the leader, with key words or phrases and time allotments provided in the margin. The leader's text is *not* meant to be a verbatim script. It does provide both directions for leading activities and summary content for making presentations and facilitating discussions and group exercises.

At the end of each unit, the full "text" of the *resource papers* that supplement the unit, any role-play profiles and instructions (for duplication) and scripts for filmstrips are appended.

The companion volume to the **WE CAN HELP Leader's Manual** is the participants' "textbook," which contains all of the **WE CAN HELP Resource Materials** included in the Leader's Manual. If the participants' Resource Materials are not readily available or there are insufficient copies, the necessary resource materials should be duplicated from the Leader's Manual.

The audiovisual materials may be purchased (and the films may be rented) from:

National Audiovisual Center (NAC)
General Services Administration

Order Section/BB
Washington, DC 20409

The filmstrip/cassette recordings require a filmstrip projector and cassette tape recorder. The cassettes have audible and inaudible advance signals for synchronizing either manual or automatic advance of frames. The 16 mm. films require a standard 16 mm. sound movie projector. Detailed order information on films and filmstrip/cassettes is available in Appendix F.

III. THE CURRICULUM'S APPROACH

WE CAN HELP is a curriculum that is based on certain premises about the nature of child maltreatment and the appropriate ways to go about preventing and treating it.

- Children whose physical and emotional health and well-being are endangered by parental (or caretaker) abuse and neglect need to be protected by the community.
- Parents (or caretakers) whose behavior threatens the health and well-being of their children need help and support in order to change that behavior.
- Help for abused or neglected children and their parents (or caretakers) requires responsible, coordinated action on the part of a wide array of professionals, service agencies and citizen advocates.
- Legal frameworks constructed to provide authority for interventions into family life, to provide protection for children and to aid parents in changing their harmful behavior should be supported rather than circumvented.
- In the final analysis, child protection requires that individuals and agencies accept responsibility to act on behalf of endangered children, cooperating with one another to ensure that the necessary preventive, protective and treatment services are provided.

The curriculum is built on these general concepts. Its effectiveness depends, in part, on the way it is wedded to community-specific needs for a more adequate child protective system as well as the community's goals for meeting those needs. The curriculum and, indeed, training are just the first steps. They provide a tool for developing greater sensitivity, knowledge, commitment and skill on the part of individuals who have responsible roles in child protection; and a tool for organizing community agencies and organizations into a network of child protection and family support.

The curriculum uses a number of types of activities, both didactic and experiential. Didactic approaches include presentations by the leader or invited resource persons. The Leader's Manual provides the skeleton of these presentations. They are deliberately not labelled *lectures*. The curriculum uses the term *presentation* to underscore the informal, conversational style which is most effective for learning. In a more didactic manner, the filmstrips and films are meant to convey information directly to participants. And finally, the resource papers which parallel and expand upon leader presentations and audiovisual presentations are a form of didactic teaching.

Experiential approaches in **WE CAN HELP** are most often group or individual exercises in decision-making. Sometimes, they are focused on individual feelings and the relationship of those feelings to the children and families who are caught up in abuse and neglect problems. In one case, an experiential form of learning (brainstorming) is used to gain clarity about professional biases and stereotypes.

More specific information about the types of training activities incorporated into the curriculum is provided in Appendix D. One more note about terminology: *Leader* and *participant* are consistently used instead of *trainer* and *trainee* or *teacher/instructor* and *student*. The terms, *leader* and *participant,* best reflect the style and the relationship inherent in the **WE CAN HELP** curriculum.

Finally, this curriculum's usefulness depends on how it is tailored to the structural/organizational and cultural uniqueness of the local community. Such tailoring includes everything from using the appropriate names for agencies (Is it Protective Services, CPS, Child Welfare, etc.?) to styles of learning which might be considered offensive in some communities. To adjust the curriculum appropriately, leaders need to know the community, its service structure, the participant audience and the curriculum well. Only then will leaders be in a position to present this curriculum in a way that will encourage full participation and learning.

IV. HOW THE CURRICULUM MAY BE USED

WE CAN HELP may be used to:

- Orient staff members of various agencies and various professions;
- Orient representatives of the community at large;
- Increase knowledge and skills of practicing professionals, support staff and volunteer workers, in inservice training sessions; and
- Develop knowledge and skills as a part of a preprofessional curriculum.

Experience with use of the curriculum suggests that the dynamics produced by a multidisciplinary/multiagency participant audience are most conducive to a positive learning experience. Even when it is to be used for inservice training, planners should invite staff from other agencies or institutions to make the training sessions a joint learning experience.

The dynamics of the training are different, at least at the beginning of sessions, depending on whether participation is required or is optional on the part of each participant. If participants attend the training sessions because they are required to do so, the leader's role includes the need to deal with the possible negative attitudes which participants bring with them. These attitudes (expressed often as "I could be back at my desk dealing with all that paperwork that has piled up, rather than wasting my time here") can cause barriers to participation and learning. In any case, adequate planning and advance communication with participants are vital to effective training.

The curriculum is designed to be used as a whole in the given sequence, with units building upon each other. However, it is possible to select specific units for single training sessions and even discrete activities for brief training events. In most cases of such selection, more rather than less advance planning will be required to prepare an appropriate context, making the selected unit or activity self-contained.

The curriculum may be presented in a concentrated, sequential manner, over the course of four full days; or it may be presented a unit at a time over the course of eight or more weeks. Experience with the curriculum suggests that spreading out the training over a number of weeks, with time in between units to allow participants to absorb their new knowledge, to adjust to changing attitudes and to practice new approaches, is the more effective approach.

V. POTENTIAL PARTICIPANTS

WE CAN HELP was designed for education, law enforcement, social work and medical professionals. In the course of using it before its final revision, it became clear that staff in other helping roles and citizen advocates also profitted from participation. Some participants—such as judges, physicians and attorneys—were invited to be special resource persons, but found themselves involved in learning as well as in teaching.

Before excluding anyone from the list of potential participants, one should ask: (1) in the context of their work, do participants have contact with children and families; and (2) are the potential participants in a position to help, either by reporting suspected incidents of child abuse and neglect or by providing services to children and families who are suffering from the problem? Such selection criteria expands the list of potential participants to include others; for example, clergymen, pharmacists, school custodians, bus drivers, cooks, recreation leaders and aides and volunteers in youth and children's organizations.

VI. LEADER QUALIFICATIONS

To lead the **WE CAN HELP** curriculum, a person needs a combination of knowledge about child abuse and neglect and skill as a group leader.

The leader must be familiar with child abuse and neglect and the approaches that the community is using to prevent and treat the problem. A person with good leadership skills but little or no knowledge about child protection issues will soon be found out by a questioning group. The leader does not have to know *all* the answers to all the questions; but he or she had better know some of the answers. In addition, the presentations in the curriculum will only come alive for participants if they are supplemented with examples. (CAUTION: The leader who uses actual case material must protect the privacy of clients who might be known to and recognized by the participants.) For subjects about which leaders do not judge themselves adequately knowledgeable, resource people should be invited to make the prescribed presentations.

The leader must have skills as a group leader, both as a presenter of information and a facilitator of group discussions and group exercises. A leader who knows child abuse and neglect inside and out but is uncomfortable directing a group's activities will probably lose participants. An "audience" may be left in the room, but there will be no participation.

Either the leader or someone on the training staff needs organizational skills. The successful training session itself is the result of a lot of planning and organization. A good leader with good material can be completely undermined by logistical foul-ups resulting from lack of foresight about what will be needed on-site or lack of organizational ability to get it there.

The leader of this particular curriculum needs self-awareness. The curriculum deals with two areas in which individuals often have blind spots—their feelings about parents with child abuse and neglect problems and their biases about different professionals. It is likely that the leader who has not deliberately attempted to clarify his or her own attitudes will suffer from these blindnesses, too. These feelings and biases will be communicated, probably in an unconstructive manner. Advance preparation—reading and rereading the material and previewing the audiovisuals—will give the leader an opportunity to gain insights to attitudes that block rather than facilitate participants' learning. For example, in a multidisciplinary session with social workers and police officers, certain stereotypes can be expected. One purpose of the curriculum is to assist these two professional groups in learning to work together as they define their roles in the child protective process. A leader who "sides" with one over the other will probably prevent learning.

A final leader qualification, perhaps not absolutely essential, but certainly desirable, is *humor.* Child abuse and neglect is serious, frightening to some, a cause for anger in others and very saddening to most. It is very important for everyone's ability to absorb information and be willing and able to act upon it that there be light moments, times to smile and even to laugh. The leader's style of presenting and facilitating will be the main ingredient in determining whether such humor is allowed and valued as a part of the learning experience.

VI. PLANNING AND PREPARATION TO USE THE CURRICULUM

In addition to those preparations that involve logistics and becoming thoroughly familiar with content, four areas of planning and preparation are crucial for successful use of the **WE CAN HELP** curriculum. *This training requires the commitment and active support of the top management of the agency or agencies whose staff will be recruited as participants.* Support is necessary both for pretraining and post-training reasons. Before the training sessions, agency management will be needed to aid in recruitment (for example, by allowing release time for staff to attend) and in making adequate logistical arrangements for space and equipment. After the training, agency management support will be required if participants are to be allowed to practice what they have learned and to follow up on the interdisciplinary planning and consultation which **WE CAN HELP** has stimulated. This guideline is especially important if the leadership and preparation for the training is provided by "outsiders" to the agency. In effect, the curriculum, the approach to training and the need for training must be "sold" to the decision-makers, and their involvement in making specific plans should be solicited. The first step in planning to use **WE CAN HELP** should be in the director's, supervisor's or administrator's office.

The second step involves an assessment of the target audience's training needs. An informal approach to this assessment, which involves personal conversations with agency management and staff, will probably be as effective as a formal written questionnaire. The boundary lines of **WE CAN HELP** are set and can be shared using the unit descriptions or goals; but within those boundaries, the content can be adjusted, expanded and supplemented to meet specific problems. One word of caution: Before deleting sections, particularly those on identification, because an assessment suggests that participants are already familiar with that content, consider presenting at least an abbreviated version of it as review. Experience with **WE CAN HELP** suggests that many professionals find they did not really know what they thought they knew or find a review of familiar material helpful.

The next step is to assess logistical requirements, especially regarding the scheduling and the site. In planning for multidisciplinary training sessions, time can be one of the most difficult factors to arrange so as to allow ample opportunity to present the curriculum and allow for full, continuous participation. Selecting the site may be less difficult, but it should be carefully chosen not only with concern for sufficient space and facilities but also with consideration for accessibility to participants. It should be close enough to encourage attendance, but far enough away to avoid unnecessary interference by daily, routine work requirements. Logistical requirements (including space, additional staff or resource people, equipment, audiovisuals, and duplication of materials) are listed at the beginning of the curriculum units.

The final specific point on planning and preparation has to do with recruitment of participants. Whether participants have been required as a part of their jobs to attend or have chosen to attend, they should all have advance notice of what to expect. An initial invitation to participate can provide a general agenda of the units to be used and the schedule. For those who preregister, a more thorough preparation can include the unit goals and the resource materials. Participants can be asked to read resource materials before they come to the training sessions, but realistic planning should reckon with the fact that not all of those who participate will have read materials in advance.

In the appendices which follow, a number of helpful guidelines are provided which have general applicability for preparation and planning of training sessions.

APPENDIX A

PLANNING AND PREPARING FOR A TRAINING EVENT

3 MONTHS BEFORE EVENT:

- Review curriculum and decide who the training audience is to be.
- Estimate costs and number of trainees desired.
- Identify potential training sites.
- Get top management's cooperation
- Prepare and execute needs assessment.

2 Months Before Event:

- Review needs assessment information and draft a training design.
- Identify and contact guest experts, checking for availability on dates of training, material and equipment needs, honorarium. Write confirming letter.
- Identify and contract with additional trainers if needed; set dates for training of trainers.
- Select and contract for training site.

1 MONTH BEFORE EVENT:

- Review needs assessment information and finalize the training design.
- Lead trainer walk through entire training design.
- Identify and duplicate training materials.
- Identify and purchase needed supplies (e.g., felt-tip pens, masking tape, large sheets of paper, easels, etc.).
- Identify and contract for equipment needed—projectors, screens, tape recorders.
- Review pre-registration list and check budget estimates.

2 WEEKS BEFORE EVENT:

- Check to see that training design is still workable, materials are duplicated and organized by curriculum unit, supplies are purchased and boxed for transport, equipment is available for both the orientation of training staff and the actual training event.
- Orient training staff.
- Review pre-registration list and check budget estimates.

1 WEEK BEFORE EVENT:

- Contact all guest experts to make sure they are still available; identify back-up people in case of emergency.
- Visit the site and make final arrangements with site manager and key staff (cook, housekeeper, business manager).
- Prepare visual aids and/or last minute training materials such as copies of the agenda, site and area descriptions.
- Meet and review all arrangements with "gofer" support staff, making sure that each person knows what his/her individual tasks are.

APPENDIX B

GUIDELINES FOR SELECTING A TRAINING FACILITY

Identifying an appropriate training facility. Some of the sponsoring agencies will, of course, already have facilities that they use for training purposes. For example, schools and social work agencies commonly conduct service training programs, hospitals provide training through grand rounds or seminars, and law enforcement officers are often trained in special "schools" where they learn advanced skills or train for promotional examinations.

If these facilities are too small or inappropriate for this training program, appropriate facilities may be available through local colleges or universities, convention centers, hotels or motels. In addition, there are numerous well-known privately owned and operated training centers throughout the country including some sponsored by foundations, religious organizations, or major corporations.

Some training facilities provide a complete package, including overnight accommodations for participants, conference rooms, audiovisual equipment and a support staff trained to assist in conference registration, the use of audiovisual equipment, etc.

Conference facilities are frequently booked several months in advance so if the training program will involve a large number of participants (75 or more) or require overnight accommodations for participants, it would be advisable to reserve the facility two to three months in advance.

Assessing the appropriateness of a facility. The curriculum requires one large room for every 20 participants. The room should be spacious enough to allow for four small groups of five participants to meet in the room without interfering with each other's work. For those units with audiovisuals, the room should have curtains or some other means to shut out exterior light.

To determine whether a particular training facility is appropriate, the person responsible for planning the training program should visit the facility personally, and ask to see the *exact* rooms that will be used—not *similar* rooms. In addition, check the following points for each room to be used for training:

1. Can posters, charts, diagrams, etc., be mounted on the walls? If so, what kinds of fasteners are permitted (tape, push pins, magnets, etc.)?
2. Is the room relatively sound-proof or reasonably isolated from major sources of noise such as street sounds, kitchen operations, banquet halls garbage, disposal equipment, construction, etc.?
3. Can the room be darkened sufficiently to permit viewing of slides and films—i.e., are there drapes or heavy shades?
4. Is the room well ventilated or heated? Is the ventilation or heating system exceptionally noisy? Is there a thermostat in the room?
5. Does the room have adequate and conveniently located electric outlets? Are they two-prong or three-prong outlets?

After checking each room, the person responsible for planning the training should also seek to determine:

1. Whether the training facility has audiovisual equipment available. If so, what type is it and does it meet the specifications for the equipment required by the curriculum? What is the cost of using it?
2. Whether registration for the program can be conducted in the lobby or other clearly visible area and whether the facility has a system for posting information on the location of conference rooms, etc., in various central places.
3. Whether the facility has coffee, tea and soft drink machines conveniently located near the training rooms and whether refreshments can be ordered for morning and afternoon coffee breaks. (If trainees have to go any distance to satisfy their needs during breaks, it is often hard to reconvene on schedule.)
4. Whether there is parking available on or near the training site, and whether a fee is charged. (If trainees are provided with this information prior to the conference, it will help to eliminate late arrivals,

particularly on the first day of the conference).

5. Whether the training facility has a map or printed directions for reaching the facility. (Conference centers located outside of downtown areas have maps or directions available for inclusion in pre-conference mailings to trainees.)

Finally, it is advisable for the person responsible for planning the training to identify nearby restaurants and get a sense of what kinds of food they serve and how expensive they are. This information can then be compiled for distribution to trainees as part of the conference registration packet.

APPENDIX C

GROUND RULES FOR TRAINING

The following is a list of issues which frequently surface in training and are generally of concern to participants. They often require that a leader be prepared to help define the issue, identify options for behavior, and negotiate conflict to achieve some kind of compromise.

Smoking
Room Temperature
Lighting
Seating Arrangements
Arguing
Talking Too Much
Value Conflicts
Being on Time
Not Participating in Training
Absences
Quiet Time and Noisy Time
Evaluating Training and the Trainer
Room Arrangements
When to Take Breaks
Availability of Coffee, Tea, Soft Drinks, and Snacks
An Agreed-Upon Process for Registering Complaints

A leader need not identify all of these issues for participants during the opening negotiations, only those pertaining to interpersonal interaction. When issues surface, a leader should be prepared to help the group members identify options (e.g., smokers can take breaks, sit by the windows or door, smoke during training sessions at will) and help the group reach consensus about how to proceed.

Some suggested ground rules for training behaviors are:

1. Every experience is a learning experience, whether it is a planned lesson or something that happens spontaneously in the group, and, therefore, should be examined for educational value.
2. In order to use each other as resources we must be able to communicate openly and honestly.
3. You are responsible for your own learning; if you are not getting what you want from this session, it is your responsibility to ask for it.
4. We can only discuss each other in terms of the here and now situation. Therefore, any communication about a person's behavior must relate specifically to what happens in this training.
5. When in a discussion, each person must take ownership for his or her own statements. The group will give feedback when this is not happening. Use "I" instead of "people say" or "I heard" or other statements that obscure the fact of talking about what "I" think or feel.
6. Any issue raised that relates to training is a legitimate issue for group consideration and it is everyone's responsibility to bring these issues to the group.
7. Sometimes when we communicate about the behavior of others, the communication is distorted because we do not distinguish between what we observe, what we think about, what we observe and, if applicable, what we feel as a result of our observation. Therefore make distinctions in your communication, among your observations, thoughts and feelings.

APPENDIX D

HOW TO USE VARIOUS TRAINING TECHNIQUES AND METHODS

1. TRAINING CONFIGURATIONS.

The curriculum calls for four different types of training configurations: dyads, triads, small groups, and large groups. Each of these configurations can be formed in different ways and each has different purposes.

Dyads.

Two people form a dyad. Dyads are specified in a number of activities in the curriculum. They are particularly valuable in situations where a direct and in-depth exchange between two individuals is desirable. Dyads often stimulate the expression of emotions and feelings that people find hard to express otherwise; when properly used, they have a compelling quality.

1. Dyads can be structured informally by asking participants to work with the person sitting next to them at the training session.
2. Dyads can be formed between people who are similar. For example, dyads can consist of two social workers or two physicians or two people from the same community. Pairing similar people can often give participants the comfort of someone they share implicit assumptions with or someone who they know has common information.
3. Dyads can be formed between people who are dissimilar—a social worker and a police officer, for example, or a school superintendent and a nurse. Pairing dissimilar people often gives each participant a different perspective.

Any type of dyad can be formed by asking participants to volunteer for dyads, or participants can be assigned to dyads by discipline.

Triads

Groups of three people, generally serve the same purpose as dyads, with the important exception that the third person is frequently assigned to observe the process between the other two people.

Small Groups.

Four to six people form the type of small groups specified in the curriculum. They are particularly useful in those situations where it is desirable to involve participants actively in discussion or skill-building exercises. Small groups are also very useful in situations where it is desirable to build a sense of cohesiveness and familiarity among a large number of participants. Finally, small groups allow for the maximum exchange of information between participants.

Leaders can use several methods in forming small groups:

1. They can be formed on a multidisciplinary basis. To the extent possible, small groups can be designed to reflect the make-up of the larger participant group. In most cases, however, since some disciplines may be only minimally represented, it will probably not be possible to have all of the disciplines represented in each group. The advantage of multidisciplinary groups is obvious: they provide an opportunity for the members of the various disciplines to share their opinions with each other and to obtain insights about other disciplines' perspectives.
2. Single-discipline groups can be formed as well. In those instances where an activity calls for a single-discipline group, a leader can either segregate the various subgroups in each discipline (in a group of medical and health professionals, for example, nurses might be assigned to one small group and physicians to another), or assign them to the same groups.
3. Depending on the range of geographic backgrounds of participants, some activities calling for small groups could be organized on a geographical basis. That is, they may be composed of people from the same State, county or city regardless of discipline. Groups formed in this way are advantageous in those instances where there are significant State or local variances in procedures (such as various State child abuse and

neglect reporting laws), or where the training is aimed at developing local plans or commitments to cooperation within communities.

4. Finally, some of the training activities are designed for groups composed of people who work for the same agency or program. The membership of such single-agency groups may be multidisciplinary or single-disciplinary. For example, if the agency is a hospital, the group may include physicians, nurses, medical social workers, health educators, etc.; and, if the agency is a Child Protective Services agency, the group may be comprised solely of social workers. Single-agency groups are useful in those activities directed at developing policies or procedures suitable for that particular agency, or at developing working relationships which are to continue in force after the conclusion of the training program.

Large Groups.

For the purposes of this training, a large group refers to the entire training audience, up to but preferably not exceeding 20 people.

Large groups are called for in the basic curriculum for introductions, for viewing films and filmstrips, for presentations and in those situations where small groups come together to report upon small group activities. While not conducive to individual participation, the large group structure is an efficient way to disseminate information to a large number of people. It is also advantageous in situations where the trainer wants the entire group to receive the same information and may be preferred when there is a need to develop consensus or make group decisions. It is also useful for feedback and exchange of information generated in the small group activities.

In forming large groups the leader should be attentive to the following concerns:

> It is important to specify in advance when the large group will convene so participants do not straggle in from small group or other activities in ways that are disruptive or wasteful of time.
>
> It is important that all participants be able to see and hear with ease.

2. TRAINING TECHNIQUES.

To use the curriculum units effectively, leaders need to be familiar with and practiced in the use of a number of different training techniques. Some techniques are designed to involve participants in generating ideas. Some techniques are designed to get at participants' feelings and emotions. Some are designed to help participants develop insights and skills and others are designed to encourage the exchange of information.

Brainstorming.

The primary purpose of "brainstorming" is to generate ideas, to involve participants in alternatives and creative solutions without any criticism or analysis. It is based on an assumption that the interaction of the group will stimulate both more active participation and the development of more creative ideas.

Brainstorming is sometimes conducted in small groups in order to increase the degree to which individual participants are able to actively participate. The following limits may be helpful to leaders who are responsible for planning and conducting a brainstorming session:

1. Explain the purpose of the brainstorming session to participants by saying, for example, "The purpose of this brainstorming session is to come up with ideas about ways that we can get the newspapers, radio stations, and television stations involved in child abuse and neglect prevention."
2. Inform participants that only a limited time period will be allocated for brainstorming; tell them exactly how many minutes. In general, brainstorm sessions should never run more than fifteen minutes, and five to ten minutes is the norm. The purpose of setting firm time limits is to create a sense of urgency. To increase the sense of urgency it is sometimes helpful to let participants know when three minutes are left, two minutes and one minute.
3. Be prepared to record the ideas that participants generate. It is best to use large sheets of easel paper, or a blackboard for this purpose.
4. Tell participants what the usual rules are for brainstorming sessions.
   (a) Encourage participants to speak out and express their ideas spontaneously. People usually do not take turns in brainstorming ses-

sions, although it is possible to go around the circle in turn.

(b) Participants are encouraged to contribute "wild" ideas as well as those that they feel are practical or realistic. Encourage participants to be creative, to share their dreams. You might remind them that Einstein once said that imagination is more important than intelligence.

(c) No critical review of ideas is allowed during the brainstorming. Participants are not allowed to comment on or disparage one another's ideas (by gesture, expression or verbally). The purpose is to generate lots of ideas rather than to analyze the possibility of ideas. Let participants know that after the brainstorm session is complete there will be opportunities to review, discuss and analyze all of the ideas on the list.

5. The leader should encourage and support participation by all. This can be accomplished by offering supportive comments (e.g., "good idea," "fine, we have that down," or "good, we'll add that to the list"), by calling directly on less aggressive or quieter participants, or by structuring the brainstorm session so that each participant has a turn to speak. If a leader does use the latter approach, participants should also be informed that they can "pass" when their turn comes if they wish.

Leaders may also need to repeat the rules and caution group members who make critical or negative remarks about another participant's contributions.

6. At the conclusion of the brainstorm session there are several ways to deal with the list of ideas that was generated. It can be discussed and analyzed by the group, or exchanged with other small brainstorm groups to share ideas, or the ideas can be ranked in order of priority by the group. How they are used depends on the specific purpose of the brainstorm session and the kinds of training activities that follow the brainstorm session.

Feeling Sessions.

This technique is used to help participants become aware of their own feelings and emotions, and those of other group members. It is also used to "give permission" to participants to acknowledge the fact that they have those feelings.

Feeling sessions are usually conducted in dyads, triads, or small groups. They are easy to structure.

1. Tell participants what the topic is (e.g., feelings about parents who abuse their children), and inform them that the purpose of the feeling exercise is to help them become aware of their feelings and those of other group members.
2. Tell them that they will be divided into dyads, triads, or small groups. Each person will then be allowed a specified period of time (usually two to three minutes) to tell the other what they feel about the topic.
3. The leader should direct trainees to begin each statement they make with an "I feel" phrase (e.g., "I feel angry at parents who abuse . . . ." It is very important that participants be repeatedly reminded to focus on feelings and emotions. If they aren't, they tend to intellectualize. The surest sign that trainees are intellectualizing is the use of "I think . . ." or "I believe . . ." phrases.
4. Other members of the dyad, triad, or group should be directed to listen attentively to the participant who is expressing his or her feelings, and to try to avoid making either negative or positive comments, gestures, or facial expressions.
5. After each participant has had an opportunity to express his or her feelings, the leader should acknowledge that it is often difficult for people to express feelings about topics as evocative as child abuse and neglect, and thank the participants for their willingness to share their feelings with each other.

Goals Negotiation.

This technique is for generating ideas, setting priorities and getting agreement on goals for the entire group.

This technique is especially valuable at the start of a training session. It provides a group experience in which members have a chance to meet one another, work together, share ideas and successfully achieve some limited objectives.

The goals negotiation process encourages everyone to participate in the group and facilitates participation by more reticent people as well as those who are more gregarious. Thus, everyone in the group can feel some "ownership" of the goals that are ultimately selected. Once a group has negotiated and selected its own training goals it is usually easier for the leader to keep the group focused on its goals.

To begin the goals negotiation process, each participant is asked by the leader to identify up to four goals for the workshop conference. ("What would you like to get out of this conference?" or "What do you most want to accomplish in this workshop?")

After each individual has identified his or her goals, the leader will instruct each person to find a partner and form a dyad. In each dyad, participants should be instructed to share their goals with each other, compile a list of their eight goals (four from each member of the dyad), and then negotiate with each other to select the four most important goals. The leader should allow five to ten minutes to accomplish this.

Next, the leader should direct each dyad to take its list of four goals and join with another dyad. As a group of four they will share their goals and negotiate with each other in order to narrow the two lists down to the four most important goals. (Another five to ten minutes should be allocated for this purpose). The process is then continued until the groups are joined into a single group with a single list of four goals.

At this point the leader should ask if anyone believes an important goal has been overlooked or lost in the shuffle. If the group concurs, other goals can be added.

The leader may want to mediate in instances where a goal selected as important by the group is clearly not in the domain of the training. If this occurs, the leader should acknowledge that this *is* important, explain why it will not be covered and, if possible, suggest where this information might be obtained.

The leader should conclude this exercise by getting group consensus, e.g., "So are these the things you all want us to focus on?" or "Are we agreed that these are the things you want to cover in this workshop?"

Role-Play. This technique is particularly useful for developing sensitivity to the feelings and concerns of people in particular roles or situations, and for providing participants with an opportunity to develop and practice various skills in simulated situations. Role-playing is vivid and dramatic, active rather than passive, and can be one of the most powerful training tools.

Role-play.

This can be conducted with groups of almost any size, although it is best suited for small groups. Leaders can utilize role-plays in a variety of ways: several role-plays can be conducted simultaneously, each with a small group of observers; the entire group of trainees can be divided into dyads and each dyad assigned a role-play; or, a selected group of participants can act out the roles while the rest observe.

The following hints should help leaders to use role-playing techniques successfully:

1. The purpose of the role-play should be clearly stated—as to whether it is to provide participants an opportunity to experience other people's roles and feelings, or to develop skills. For example, the leader might tell the group, "This exercise is to help you improve your skills in interviewing parents who are alleged to have abused or neglected their children."
2. The leader should explain the general rules that govern role-playing:
   (a) Each role-player gets his or her role from role-play instructions, or role profiles. Role profiles usually describe the situation, provide descriptive information about the person in the role, and stipulate the feelings associated with the role. For example, a typical role description might be:

   > "You are a 28-year-old foreign-born mother of three children under four years of age. Your husband is in the Navy and has been on sea duty for over six months. Your family is in Europe. You don't speak English very well and you don't have any friends; Americans seem strange to you. Your youngest child is colicky and keeps you up night after night. Two days ago you shook her hard and threw her onto the bed and she fell onto the floor. You were angry and tired and lonely. When you took her to the Naval hospital the doctor discovered that her arm was bro-

ken. The doctor is interviewing you. You are scared. What will they do if they find out? Will you go to jail? Will they tell your husband? Will they take the baby away?"

   (b) The participants selected to play each role should be instructed to stay in their roles, not to shift back and forth between their assigned role and their "real life" opinions or feelings.
   (c) Participants assigned to each role should be given time to become familiar with the role profile and to "get in touch" with the role—to feel the role and try to become that person.
   (d) Role-players should be told how long they will be expected to play their role. Usually, role-plays continue for five to ten minutes and rarely last longer than fifteen minutes.

3. Those participants who will observe the role-play should be told what to look for during the course of the role-play. Leaders can structure the observation of role-plays around specific questions that observers are asked to bear in mind as they watch the role-play (e.g., Does the parent seem defensive? What does the doctor do or ask that seems most effective? Least effective? Why?). The leader can also assign particular observers (individuals or sub-groups) to observe each of the role-players.
4. During the course of the role-play the leader should be prepared to facilitate the role-play if necessary. From time to time he or she may need to remind the role-players to stay with their roles.
5. The leader should warn the role-players when the period allocated for the activity is ending. Role-players should be informed when three minutes is left, and when two minutes and one minute remain. If necessary, the leader should be prepared to terminate the role-play even if the role-players have not reached closure.
6. Discussions following role-plays are an important part of the process. In general, the leader should first give those participants who played each role time to comment on how they felt about the role they played and about the others' roles. The leader may need to be prepared to guide the discussion with specific questions, such as "How did you feel in your role? What did you feel about the other person's role?" or to ask questions based on actual occurrences during the role-play—for example, "When the doctor asked you about your relationship with your husband, you hesitated before answering. Do you remember what you were feeling then?"

After the role-players have had an opportunity to discuss and comment on the role-play experience, the leader can open the discussion to those participants who observed the role-play. Questions like those described above can be used to structure and guide the discussion.

Discussion.

Discussions serve a variety of purposes. They can be used to encourage the exchange of information and opinions among participants; to provide participants with insights into the positions and thought processes of other people and other professions; to enable joint analyses; and to develop a consensus on various issues.

Discussions can be conducted in both large and small groups. They are based on an assumption that the participants have information and ideas that are potentially valuable and useful to other participants. The leader's task, therefore, is to facilitate, encourage and support this exchange, and to channel it in productive directions. The leader may find the following hints on how to lead discussions useful:

1. The leader should clearly state the general topic or question under discussion and, if possible, write it on a large sheet of paper or blackboard.
2. If the participants are reluctant to begin the discussion, the leader might encourage participation by posing a question to the participants or to one particular participant that requires a response based on personal experience—such as "Do you feel that the film you just saw was realistic?" "Have any of you had a different kind of experience?" Leaders should be prepared with several "pump-primer" questions of this type.
3. The leader can facilitate the smooth flow of the discussion by:

   Pointing out similarities and differences between the thoughts, feelings, reactions or experiences of the participants (without making value judgments about them).

Keeping the group focused on the topic. ("That's an interesting point, but we've strayed a little from the subject. We can discuss your point later if you'd like and if the group feels we should.")

Summarizing key issues in the discussion from time to time or by bringing out the key points in a participant's comments. ("What you're telling us, then, is that through your personal experiences you've found that cultural differences may be important to consider in cases of suspected child neglect.")

Encouraging participation by all of the participants in the group—for example, by asking a reticent participant a direct question. ("Sally, you've been with CPS for a year now. Could you tell us how you felt about the reporting system when you first came compared to how you feel now?")

Limiting speakers and keeping aggressive participants from dominating the discussion. ("Thank you, Joe. Your comments have been really helpful. Now since we're a little short of time we'd better turn to someone else.")

4. The leader may find it useful to prepare a checklist of all of the topics to be covered in order to ensure that the discussion is sufficiently comprehensive.
5. If the participants ask questions that the leader cannot answer, he or she should not be reluctant to admit it, and should encourage other trainees to share their knowledge of the issues raised.
6. The leader should also take care not to impose his or her opinions in the discussion and not to imply that his or her opinions are the "right answer." However, if the leader's opinion is asked for, it is appropriate for the leader to offer it and, if possible, explain how he or she reached that conclusion.

3. TRAINING AIDS.

There are several aids to effective training that leaders should be familiar with, and learn how to use. They include wall minutes, handouts, and audiovisual presentations.

Wall Minutes.

Using sheets of easel paper to keep "wall minutes" is a way to record key points or ideas that are brought out in discussions, brainstorm sessions, feeling sessions, etc. The purpose of wall minutes is not only to record key points, but also to assure that participants are made aware that their comments, ideas, and opinions have been heard by the other participants, and to let participants *see* what they have covered and how much they have accomplished.

To use this training aid the leader will need an easel with a pad of easel paper (or a number of sheets of wrapping paper), several felt-tip markers of different colors, and a roll of masking tape. (To avoid damaging walls, it is advisable to use water soluble markers.)

It may be advisable to have someone other than the leader act as recorder so that the leader is free to facilitate the brainstorm or discussion session. It is also frequently useful to have more than one recorder in order to keep up with the comments in a rapid-fire session or to switch off with each other from time to time, since recording comments on easel paper is a demanding task.

Although some leaders use volunteers as recorders, the task is not easily performed. Some training and orientation for recorders may be necessary.

There are some hints to make this training aid effective:

The leader or "recorder" should summarize comments and quote only key phrases.

Quotes should be marked with quotation marks, and particularly important points or words should be underlined.

The leader should instruct participants that they can interrupt and correct the recorder, if he or she does not correctly interpret their comments or misses their point.

The leader or recorder can help to enliven the process (and achieve greater clarity) by changing the color of the marker that is used for each speaker, or for each different topic. The same purpose can be served by drawing a line across the sheet in a different color.

The leader or recorder can also enliven the process by using symbols from time to time. If a participant mentions that a particular agency "has umbrella responsibility for a case" the leader or recorder can use an umbrella symbol.

Leaders and recorders should also use common symbols—for example, CPS for Child Protective Services.

As each sheet is completed the leader or recorder should number it, remove it from the easel, and post it on the wall of the room. In this way, the complete record of the session is available for all of the participants to see.

At the end of a particular training activity the sheets of easel paper can be reviewed by the group, saved as a record of the group's conclusions, or posted along with the responses generated by other groups so that all of the participants get an opportunity to see what ideas, opinions, or conclusions came up in other groups' sessions.

Handouts.

The curriculum calls for the use of handouts in a number of units. In some instances, handouts should be duplicated and distributed to participants for their continuing use and reference after the training conference is ended.

Audiovisual Presentations.

There are a number of audiovisual aids included in the curriculum—films, filmstrips, and charts.

APPENDIX E

CHILD ABUSE AND NEGLECT
Resources

This bibliography has been included to provide both trainers and trainees with a listing of child abuse and neglect literature that is special, in terms of contributions to the field of knowledge. It is not all-inclusive and is not meant to be. The citations are those of articles and books that were of special help in developing the curriculum.

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APPENDIX F

TRAINING BIBLIOGRAPHY

The articles and manuals listed in this appendix provide background information on training philosophy and techniques that may be helpful to both the neophyte and the experienced leader. The list includes basic instruction on how to develop and present a training program. It is recommended that this bibliography be used to prepare the leader for training, regardless of the training design used.

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WE CAN HELP AUDIOVISUALS

Unit 1:

Child Abuse and Neglect: An American Concern (filmstrip 15 minutes) An introduction to the problem of child abuse and neglect, including estimated incidence, causes and effects. (Order No. A00786)

Barb: Breaking the Cycle of Child Abuse (filmstrip 28 minutes) A case of child abuse presented from the parent's point of view, from discovery through treatment. (Order No. A00–544)

Unit 2:

Physical Indicators: Signs of Alert (filmstrip 12½ minutes) An overview of the major external and internal physical manifestations of child abuse. (Order No. 000544)

Physical Abuse: What Behavior Can Tell Us (filmstrip 13½ minutes) An overview of child behaviors and interactions between children and parents which may indicate child abuse. (Order No. 000549)

Abusive Parents (film 30 minutes) Presentation of a videotaped panel of women incarcerated for child abuse and belonging to a prison chapter of Parents Anonymous, with commentary after the panel by Elsa ten Broeck, MSW. Commentary covers social context, personal and family dynamics of child abuse. (Order No. 000562)

Unit 3:

Identifying Neglect: Before It's Too Late (filmstrip 10½ minutes) Shows some typical forms of child neglect and its behavioral and physical indicators and includes discussion of difficulty of identifying child neglect. (Order No. 000561)

Unit 4:

Second Chance (film 13 minutes) A case study of the treatment of a child who has been the victim of emotional maltreatment in the form of maternal deprivation. (Order No. A00–543)

Unit 5:

Medical Indicators of Child Abuse and Neglect—Part 5: Sexual Abuse (filmstrip 10 minutes) Physical indicators of child sexual abuse and examination/diagnostic measures which should be followed by medical personnel in suspected cases. (Order No. 000684)

Sexual Abuse: The Family (film 30 minutes) Documentary film featuring discussion of sexual abuse of children by Raylene DeVine, M.D., Ms. Bennie Stovall and Henry Giarretto; and a role-play by professionals of interviewing child and family in an emergency room setting. Not recommended for general showing or use outside of training program. (Order No. 000612)

Unit 6:

Issues in Reporting Child Abuse and Neglect (filmstrip 15 minutes) Dramatizes a variety of reasons child case professionals may be reluctant to report cases of suspected child abuse and neglect, followed by interviews with professionals who suggest ways of minimizing this resistence and improving the system. (Order No. 000615)

Investigating Cases of Child Abuse and Neglect (film 30 minutes) Presents two dramatizations of investigations, one by a Child Protective worker in cooperation with hospital staff of suspected child abuse, the other by police of a situation involving small children left unattended. (Order No. 000623).

Case Planning and Referral of Child Abuse and Neglect (filmstrip 15 minutes) Case planning and management are looked at from the parent's and the professional's point of view, using a case history to examine process, problems and solutions. Emphasis is on interdisciplinary approach. (Order No. 000625)

Unit 8:

Working Together (film 30 minutes) Documentary film featuring multiagency approaches to child abuse and neglect in San Diego, Salina (Kansas) and Montgomery County (Maryland). (Order No. 000541)

Filmstrips (with audiocasettes) and films may be ordered from:

The National Audiovisual Center (NAC)
General Services Administration
Order Section
Washington, DC 20409

PRICE INFORMATION FOR PURCHASE AND RENTALS IS AVAILABLE FROM REGIONAL CHILD ABUSE AND NEGLECT RESOURCE CENTERS AND THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT.

Unit 1: INTRODUCTION: UNDERSTANDING CHILD ABUSE AND NEGLECT

UNIT 1

Time: 3 hours 35 minutes
3 hours 5 minutes
(without pretest
or post test)

INTRODUCTION: UNDERSTANDING CHILD ABUSE AND NEGLECT

DESCRIPTION OF UNIT:

This unit provides an introduction to WE CAN HELP: A CURRICULUM ON CHILD ABUSE AND NEGLECT. It contains: (1) a format for training staff and fellow training participants to meet and to take care of necessary housekeeping matters; (2) statement of the curriculum's training objectives and an optional pretest questionnaire; (3) an introduction to child abuse and neglect, including a framework for understanding causes and social context, relevant legal definitions and emotional reactions; and (4) a final group exercise based either on a film or a written case story, allowing participants to apply the introductory information and to consider various community responses to child abuse and neglect.

GOALS:

1. To make participants comfortable with the training site and agenda for the training session.
2. To gather pretraining data from participants on their knowledge and attitudes about child abuse and neglect (optional).
3. To provide participants with a conceptual framework for understanding the causes, social environment and legal definitions of child abuse and neglect.
4. To help participants recognize and begin to manage their own feelings toward families who abuse or neglect their children.
5. To provide a basis for participants to recognize and begin to manage their own individual and communal responsibilities in preventing, identifying and treating child abuse and neglect.

OBJECTIVES:

At the conclusion of this unit, participants will be able to:

1. Give first names of training staff and at least four other participants.
2. Define the major categories of causal factors underlying child abuse and neglect.
3. Give definitions of child abuse and neglect, as provided in participants' State reporting laws.

RATIONALE:

This introductory unit offers a framework which should be useful background for any or all of the remaining units of the curriculum. The framework includes concepts about the etiology (origins) and the ecology (environment) of child abuse and neglect. It also is concerned with the emotions about child abuse and neglect which participants bring to these training sessions; the group learning approach which calls for individual participation; and the theme of community responsibility which is the basic rationale of the entire curriculum.

ADDITIONAL STAFF NEEDED:

None.

SPACE REQUIREMENTS:

One room large enough to accommodate total group, with space sufficient to spread out for small groups of three each in Activity 7.

EQUIPMENT:

35 mm. filmstrip projector and cassette tape recorder
16 mm. sound film projector
screen
extension cord and adapter plug, if necessary
1 easel board and pad of easel paper or chalkboard
felt-tip markers or chalk and eraser.
11 placards, each with one of the following words printed on it: ENRAGED, AFRAID, HURT, CONFUSED, SAD, UNBELIEVING, SICKENED, EMPATHETIC, SORRY, GUILTY, OTHER.

ACTIVITY	TIME	MATERIALS
1. Introductions	10 min.	None
2. Leader Presentation: Housekeeping Matters	10 min.	Map, list of accessible restaurants or cafeterias, if needed.
3. Pretest (optional)	30 min.	Pretest questionnaires, pens
4. Leader Presentation: Goals of the Training	10 min.	Agenda
5. Filmstrip and Discussion	30 min.	Filmstrip: "Child Abuse and Neglect—An American Concern" Resource Paper: "Child Abuse and Neglect: An American Concern"
BREAK	10 min.	
6. Leader Presentation: Definitions	15 min.	Resource Paper: Defining Child Abuse and Neglect
7. Group Exercise: Child Abuse and Neglect—An Emotional Issue	20 min.	None
8a. Film and Discussion or	50 min.	Film: Barb—Breaking the Cycle of Child Abuse
8b. Case Vignette and Discussion	30 min.	Case Story: The Story of Susan

AUDIOVISUALS:

Filmstrip/cassette recording: *Child Abuse and Neglect-An American Concern*

Film: *Barb—Breaking the Cycle of Child Abuse*

PARTICIPANTS' MATERIALS:

Resource Paper: *"Child Abuse and Neglect—An American Concern"*

Resource Paper: *"Defining Child Abuse and Neglect"*

BEFORE YOU BEGIN:

Duplicate necessary materials, including maps, agenda, lists of accessible restaurants or cafeterias, as needed, pretest questionnaires and copies of your State's reporting laws defining child abuse and child neglect. (Sources of State reporting laws include State attorney general's office, local child abuse and neglect councils, local Child Protective Service agency or unit.) If copies of **WE CAN HELP Resource Materials** are not provided for participants, duplicate copies of the Resource Papers.

ACTIVITIES

ACTIVITY 1. Group Activity: Introductions

10 minutes
Welcome
Self-introduction

This period begins with a welcome to the training program, a self-introduction by the leader and any necessary references to training sponsorship.

Introduction of Participants

Then the leader invites participants and other training staff to introduce themselves. A number of group exercises can be successfully used to facilitate introductions and to make them more than a "name and agency" roll call.

ACTIVITY 2. Leader Presentation: Housekeeping

10 minutes

Rest rooms
Breaks-refreshments
Meals-restaurants
Overnight
Messages
Smoking

The leader briefly provides directions to rest rooms and eating facilities; explains about availability of refreshments during breaks, arrangements for meals and overnight accommodations (as required). A map of the facility or area can be helpful if participants are unfamiliar with the training site. The process for handling incoming messages should also be described. A policy or group agreement about smoking should be reached in this session.

ACTIVITY 3. Pretest Questionnaire (Optional)

30 minutes
Introduction/Purpose

The leader introduces this activity by explaining its purpose. The pretest/post-test questionnaire can be used both for self-evaluation by the participants and for evaluation of the training program's effectiveness by training staff. See page 64 for copies of the pretest and the post test.

Procedures

The leader explains that a post-test will be administered after the last session and the comparative results will be analyzed by the participants themselves or by the training staff (depending on which option is chosen).

Hand out tests

The training staff hands out the pretests and allows 25 minutes for participants to complete and hand them in.

ACTIVITY 4. Leader Presentation: The Goals of the Training Program

10 minutes

General goals

The leader briefly spells out the goals of the training agenda. These goals will be both general and community-specific. The general goals inherent in this curriculum are:

1. Knowledge

1. To increase participants' knowledge about child abuse and neglect—characteristics, indicators, appropriate and effective ways of treating and preventing.

2. To increase participants' willingness, confidence and comfort in assuming their proper responsibilities to insure that endangered children are protected and abusive and neglectful families receive help.
3. To enhance participants' skills in recognizing child abuse and neglect and in making legally and therapeutically sound decisions about how to handle suspected and confirmed cases.

2. Attitudes

3. Skills

The specific goals of the training agenda are derived from the purposes which have motivated this training program. They may include the development of a community multiagency, multidisciplinary child protection council, the accreditation of selected professionals and paraprofessionals to work with the community's child protection agency, or the orientation of various professionals and citizen advocates to the realities of dealing with child abuse and neglect. If this training is being provided with a specific "agenda" in mind, it will be best to make that agenda clear at the outset so that subsequent learning processes can be shaped and disciplined by these goals.

Community—specific goals

ACTIVITY 5. Filmstrip and Discussion

30 minutes
Introduce filmstrip

The leader introduces the filmstrip, "Child Abuse and Neglect—An American Concern." This filmstrip provides a framework for the more detailed examination of child abuse and neglect which is to follow in this curriculum. The focus is deliberately broad—on the environmental as well as the individual factors that form the setting for family violence in general and child maltreatment in particular. The filmstrip conveys both concepts and terminology which can be useful in later training activities. Participants should be told to look for the sets of explanatory factors which can aid understanding of the causes and treatment of child abuse and neglect. The factors are:

1. Individual capacities,
2. Personal attitudes and beliefs
3. Specific life situations, and
4. General community welfare.

What to look for

FILMSTRIP

Show filmstrip

Discussion:

Discuss filmstrip

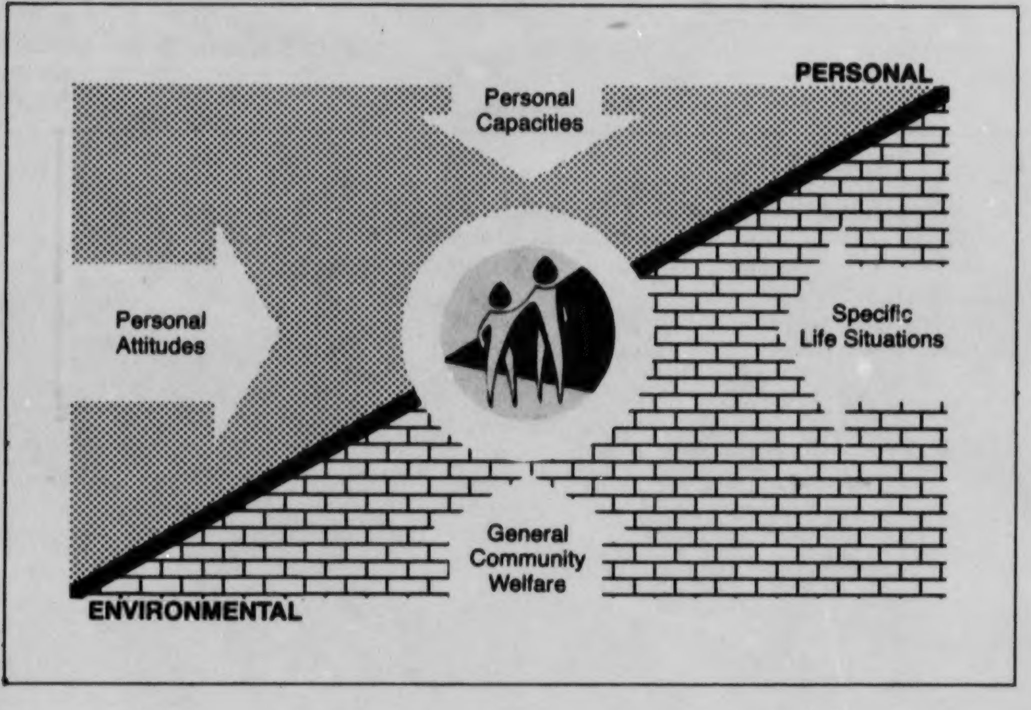
Add examples of influences

The leader may focus immediately on the content of this filmstrip and elicit from the participants the main points. By using an easel pad or a chalkboard with a drawing of the "ecology of child abuse and neglect" illustrative figure on it, the group can be led to add its own examples to each of the four categories of influences described in the filmstrip. The purpose of this discussion is to reinforce the material provided in the filmstrip; discussion should be brief and sharply focused.

Refer to Resource Paper

The leader refers the participants to the Resource Paper, "Child Abuse and Neglect—An American Concern," which provides a more detailed discussion of the

ECOLOGY OF CHILD ABUSE AND NEGLECT


PERSONAL
Personal Capacities
Personal Attitudes
Specific Life Situations
General Community Welfare
ENVIRONMENTAL

material depicted in the filmstrip. The Resource Paper is in **WE CAN HELP Resource Materials,** page 7.

BREAK *10 minutes*

(During the break, the leader or training staff should place the word placards on the walls around the round, separated far enough apart to allow for Activity 7.)

ACTIVITY 6. LEADER PRESENTATION: DEFINITIONS OF CHILD ABUSE AND NEGLECT

15 minutes

The materials for this presentation may be found in the Resource Paper, "Defining Child Abuse and Neglect," on page 17 of **WE CAN HELP Resource Materials.** These points should be covered:

Definitions and Issues

1. Legal and operational definitions of child abuse and neglect raise difficult issues of identification, reporting and child protective or court intervention. The narrowness or broadness of the definitions shape

community and individual actions to protect children.

Broad definitions

2. Too broad a definition can have a negative impact on the ability and the willingness of reporters, investigators and judges to take action on behalf of endangered children, by causing ambiguity about what is and what is not child maltreatment.

Narrow definitions

3. Too narrow a definition may make it impossible to take legally sanctioned steps to protect endangered children before irremediable damage occurs.

NCCAN's draft Model Act

4. The draft Model Child Protective Service Act, developed by the National Center on Child Abuse and Neglect, offers a definition which is specific and at the same time sufficiently inclusive of harmful child care.
   (a) "Child" means a person under the age of 18.

   Abused or neglected

   (b) An "abused or neglected child" means a child whose physical or mental health or welfare is harmed or threatened with harm by the acts or omissions of his parent or other person responsible for his welfare.

   Harm

   (c) "Harm" to a child's health or welfare can occur when the parent or other person responsible for his welfare:

      Physical

      (i) Inflicts, or allows to be inflicted, upon the child, physical or mental injury, including injuries sustained as a result of excessive corporal punishment.

      Sexual

      (ii) Commits, or allows to be committed, against the child, a sexual offense, as defined by State law.

      Neglect

      (iii) Fails to supply the child with adequate food, clothing, shelter, education (as defined by State law), or health care, though financially able to do so or offered financial or other reasonable means to do so. For the purposes of this Act, "adequate health care" includes any medical or nonmedical remedial health care permitted or authorized under State law. A parent or other person responsible for a child's care legitimately practicing his religious beliefs who thereby does not provide specified medical treatment for a child shall not be considered neglectful for that reason alone.

      Abandonment

      (iv) Abandons the child, as defined by State law.

      Inadequate supervision

      (v) Fails to provide the child with adequate care, supervision, or guardianship by specific acts or omissions of a similarly serious nature requiring the intervention of the child protective service or a court.

   Threatened harm

   (d) "Threatened harm" means a substantial risk of harm.

   Person responsible

   (e) "A person responsible for a child's welfare" includes the child's parent; guardian; foster parents; an employee of a public or private residential home, institution or agency; or other person legally responsible for the child's welfare in a residential setting.

Physical injury

(f) "Physical injury" means death, or permanent or temporary disfigurement or impairment of any bodily organ or function.

State law

5. There are various definitions of child abuse and neglect in State laws.

Criminal

- The definition of child abuse and neglect in our State **criminal (or penal) law** is:

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Juvenile court

- The definition of child abuse and neglect in the **juvenile court act,** which authorizes court intervention to provide protective services and to remove children from their parents, is:

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Reporting

The definition of child abuse and neglect in the State **reporting law,** requiring some persons and permitting others to report known and suspected child abuse and neglect, is:

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Agency definition

6. (Optional) Agencies that deal with child abuse and neglect often have their own detailed definitions to guide professional decision-making. Our agency's **operational** definition of child abuse and neglect is:

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ACTIVITY 7. GROUP EXERCISE: CHILD ABUSE AND NEGLECT—AN EMOTIONAL ISSUE

20 minutes

Child maltreatment evokes emotions

This group participation exercise can be introduced by noting that child abuse and neglect require one to deal with much more than conceptual frameworks developed to explain why they occur, or State laws and agency guidelines which provide definitions. Child maltreatment involves one's deepest emotions.

Participants move to word signs

The signs around the room describe the kinds of emotions that one can feel or encounter in others in cases of child abuse and neglect. Each participant should choose one word and move to stand or sit near that sign. The only requirement is that the participant be able to explain why that particular word was chosen. One word is "other," which allows participants to supply their own *single word* in case none of those provided on placards can be chosen.

Participants explain to each other

When each participant has chosen a word, the leader asks the group to turn to one another and explain why the word was chosen. (If the group is relatively small, each person can explain to the entire group, one at a time.) Groups may intermingle, and individuals may move to explain to each other. The leader should also move around the room, listening to the variety of explanations.

GROUP DISCUSSION

After about ten minutes, the leader asks the group to return to their seats and then leads a discussion on what they have learned about the emotional content of dealing with child abuse and neglect. If there were significantly more "votes" for some words, the leader should have the group explore why those words were chosen by the majority of the group.

ACTIVITY 8a. FILM AND DISCUSSION

50 minutes

Introduce film (2 minutes)

If the film, "Barb: Breaking the Cycle of Child Abuse," is available for this activity, the leader introduces it as a kind of "unit quiz" which will allow the participants to apply what has been discussed in this unit and begin to think about what kinds of community solutions might be brought to bear to prevent and treat child maltreatment.

The participants should look and listen for the kinds of "factors" described in the filmstrip (Activity 5) and consider the various kinds of services which are used to meet Barb's and her family's needs.

FILM

Show film (28 minutes)

Discussion:

Discuss film (20 minutes)

A discussion of the film may be facilitated by using 3 pieces of newsprint taped on the wall (or on easels) or a large chalkboard, with these headings: *Emotions, Factors* and *Services.*

Emotions

The leader first asks participants to describe their own emotional responses to this film. If the group is slow to speak, the leader may ask if anyone would now choose a different descriptive word after having seen the film (referring to Activity 7). Words describing the emotional impact of "Barb" should be written on the newsprint or board under the word *Emotions.*

Factors

The leader moves the discussion to *factors* that were a part of Barb's abuse problem with Stacey. These should be listed on the newsprint or board under two subcategories: *Personal Factors* and *Environmental Factors.* Disagreement about whether such factors as Barb's marital stress is a personal or an environmental (specific life situation) factor can be discussed, but no "right" answer need be arrived at.

Services

Finally, the leader moves the discussion to *Services,* first listing with the group's help the services actually provided to Barb and then considering what services might have been provided.

OR,

ACTIVITY 8b. CASE OF CHILD MALTREATMENT AND DISCUSSION.

30 minutes

"The Story of Susan"

If the film is not available or the decision is made not to use it, "The Story of Susan," (on page 43 of this unit) may be used to provide the material for the discussion of *Emotions, Factors* and *Services* outlined above in Activity 8a. The leader should read the story aloud and then proceed to lead the discussion.

SUMMARY: *5 minutes*

The leader ends this unit by summarizing the points that have been covered and by announcing what topic the training will address next and when.

The points which should be summarized are:

- The four basic forces affecting family interactions;
- The definition of child abuse and neglect from the State reporting law; and
- The significance of emotional responses on the part of those who seek to help the children and families who suffer from child abuse and neglect.

THE STORY OF SUSAN

Susan's memories of childhood are essentially memories of fright and confusion. The middle child of divorced parents, Susan's early years were spent mostly with her mother. Her mother worked alternating factory shifts: one week, days, one week, nights. She was unable to afford child care arrangements for the children, so they were left alone much of the time. Often there was a lack of food and guidance. When her mother was home, there was much physical abuse with repeated beatings. The children were afraid of their neighborhood and Susan was often molested by the men who hung around in the hallways of their apartment building. Susan did not tell her mother of the molestations for fear that her mother would kill the men. Susan and her younger sister often went hungry because their older brother would take all the food and beat them if they tried to take some. Going to school provided no relief. There was the problem of lack of clothing and Susan's inability to concentrate and learn.

However, once a week, she and her brother and sister visited with their father and stepmother where life was easier. Her father was good to the children, although somewhat indulgent, and was not prone to physical abuse. Her stepmother had some difficulties with the children but did not use physical discipline on them. There was an evident "tug of war" between Susan's mother and her stepmother for the affections of her father which made for a tremendous amount of confusion in Susan's feelings.

The three children used to tell their mother that they hated her. She would then beat them harder which made the screams of hate even louder. When Susan was about 12 years old, her mother decided that she could no longer cope with the children and she sent them to live, full time, with their father and stepmother. At age 18 Susan met Bill and married him. Her father strongly objected to the marriage, feeling that Bill was lazy and prone to violent anger without provocation. Susan's father said that he wanted nothing more to do with her when she married Bill. On the first day of their marriage Bill beat Susan and the beatings continued and intensified when Susan became pregnant with their first child. Susan found that she could turn to her mother to discuss her problems and confusion concerning her marriage. She found this to be somewhat ironic since she had felt hate for her mother for so long.

After the birth of the baby the beatings continued and Bill refused to keep a job. Susan felt that someone needed to bring in money to support the family so she applied for a job. Bill became angry and would beat her about the face so much that Susan was more and more embarrased to go to work with blackened eyes. She quit her job and went on welfare. At that point Bill started running around with other women.

Susan attempted suicide and, when taken to the hospital, was treated medically but was told by her husband that he couldn't stand her. Susan felt that the suicide attempt was a waste of time and energy because it had not suceeded in getting the sympathy and attention she sought from her husband. Bill continued the beatings which also resulted in several trips to the emergency room for medical treatment. However, when Susan tried to find emotional support at the hospital, her requests were ignored and she was sent home. Susan often ran away but Bill would find her and bring her home again. Two more children were born. When Susan called the police after the beatings, the police arrived, told Susan that she and her husband would have to solve their own problems, and then left them to their own resources. One night, however, the oldest child Jimmie stood and watched as the police beat Bill with a night-stick.

Finally, with financial support from her sister, Susan went across country with the children. There, she found life better but Jimmie had become a problem too great for her to handle alone. Jimmie's only reaction to stress and uncertainty was violence. Susan feared for his ability to manage himself when he started school, which would be soon. She also feared her own part in her management of the child. She was beating him much more than she knew she should but felt unable to control herself. She was also beginning to have problems with her other two children. She began to look for help, but, because she was a welfare recipient and on Medicaid, no one seemed willing to help. She was told that she had to pay cash. She never had enough cash to cover the expense. She begged for help and cried out "But, I can't take it anymore. I can't stand it. I'm afraid I'm going to hurt him." One day Jimmie "sassed" her and hit at her. Before she really knew what was happening she beat on him and shook him until he lost consciousness. She became terrified and called an ambulance. In the hospital, Jimmie was diagnosed as having a subdural hematoma and numerous bruises. He remains in the hospital. Protective Services has been called.

CHILD ABUSE AND NEGLECT: AN AMERICAN CONCERN

INTRODUCTION

It is frequently remarked that America is a youth-oriented culture. While this is true in many ways—from clothing styles to choice of foods—the fact remains that in another way Americans do not really care very much for children. One evidence of this is the size of the problem of child abuse and neglect in the United States.

Although children have always been abused and neglected, until recently the problem was considered only in terms of individual cases—people knew "that fellow down the block is pretty hard on his kids," without realizing "that fellow" had thousands of companions. Not until the definition of the "battered child syndrome" in 1962 was significant public and professional attention focused on the problem that ranks as one of the greatest risks to the health of our nation's children.

Since then, hundreds of thousands of cases have been opened to child protective intervention, and hundreds of studies on various aspects of the problem have been conducted. Nevertheless, child abuse and neglect remain issues difficult to define, to assess, and extremely challenging to deal with. The goal of this resource paper is to discuss the concepts which have shown validity in providing a framework for understanding child abuse and neglect. While by no means exhaustive, the information in this paper is valuable background for discussion of the topics in the filmstrip, *Child Abuse and Neglect: An American Concern,* among the participants in the training program.

THE NEEDS OF CHILDREN

As stated above, child abuse and neglect are very difficult to define; variables which contribute to this difficulty will be discussed below. It is possible at once, however, to list the fundamental things which children need in order to live and grow, both physically and emotionally.

First is the need for a healthy fetal environment. This means the absence of dangerous drugs and diseases and the presence of adequate nourishment in the mother's body. There are also some indications, as yet tentative, that how the mother feels about herself, her unborn child and her family may also contribute to the quality of the fetal environment. After birth, and throughout life, the child has basic physical needs for adequate food, shelter and rest. In addition to basic physical needs, the child, especially the newborn, has basic emotional needs, which include the needs to give and receive affection, and to be touched in a nurturing way. Touching is particularly important for the young child, who cannot communicate verbally and experiences his/her parent's love through holding, fondling, and caressing. While it is not necessary for nurturing to be provided solely by the mother, the child must be encouraged to develop an emotional attachment to some caring person. Affection and nurturance are as essential to the infant as food and shelter. If deprived of them completely, the infant moves rapidly towards death. If they are present, but inadequate or inappropriate, the infant will develop abnormally.

As children develop, they need to be stimulated, both sensorily and cognitively, and to have opportunities to gain mastery over both their own bodies and their immediate environments. In doing this, children begin to develop a sense of "self" as unique beings separate from (although still dependent on) their parents, and to develop problem-solving abilities which permit functioning in the world.

The ability to display mastery has an effect on children's developing self-esteem, which comprises not only children's respect for themselves, but also the ability to accept the respect and love of others. Children's self-esteem is affected by the quality of interactions with their families and significant others. Children whose needs to develop self-esteem have never been met have a good chance of becoming immature, irresponsible adults.

Children also have a need for moral guidance—specifically, for socialization into the types of behaviors appropriate within their culture. A lack of moral guidance severely limits the quality of the human relationships of which children will be capable both as youngsters and in later life.

Finally, children have a need to feel safe and secure, to feel there is a measure of consistency in their lives which ensures that their basic needs will be met regularly and predictably. The concept of safety implies an absence of physical danger in a child's environment: no threat of attack, no dangerous animals, no hazardous conditions such as open fires or poisons. In addition, children need to feel secure in the love of their caretakers, and to feel in no danger of losing that love through accident or their own behavior.

Given these generally recognized needs of children, we are able to define "child maltreatment" as the omissions or commissions of parents or other caretakers which prevent these needs from being met and which prevent children from becoming productive, independent human beings with respect for themselves and for others. Specific definitions of child abuse and child neglect will be discussed below.

Obviously, the absence of basic physical requisites—food, shelter, rest—presents serious hazards to the physical health of children. The absence of basic emotional care can also be physically dangerous to children, as manifested in failure to thrive.

The absence of these elements of basic care can interfere with children's abilities to meet needs for cognitive and motor mastery, and self-esteem, since needs basic to physical survival always take precedence. In the same way, the need for safety, possibly expressed in a need not to be battered, takes precedence over other cognitive and emotional developmental needs.

DEFINITION OF CHILD ABUSE AND NEGLECT

While the needs of children can be largely agreed on, a specific definition of child abuse and neglect is harder to derive. Part of this difficulty comes from the fact that child abuse and neglect must be defined within the culture and value system of the community in which it takes place, and ideas about what is proper child-rearing practice vary widely. Many communities and social groups believe that a good parent is strict and makes liberal use of physical discipline, which will not harm children, and is, in fact, good for them. A person from such a community might consider vigorous beating of a child completely appropriate, and might even consider other parents who refrain from such behavior to be guilty of neglecting their children's moral development.

Even within one community, there may be problems in definition. Everyone might agree that physical discipline that results in broken bones is abuse, and failure to feed an infant is neglect, while discipline by reinforcement of positive behavior is characteristic of good parenting. Between these extremes, however, there exists a wide "gray" area in which it is less easy to classify parental behavior. It is within this gray area that definition is at once most necessary and most difficult.

In light of these considerations, one might propose a conceptual definition of child abuse and neglect as a form of parenting which lies towards the end of a continuum stretching from positive and socially acceptable parenting at one end, to negative and unacceptable parenting at the other. Everyone's value system contains such a continuum, and it is a function of one's cultural background, professional role and personal values where a particular action or pattern of interaction is placed. Thus a social worker who believes that all children should be given the opportunity to become self-actualizing might draw the line between acceptable and unacceptable parenting quite deeply into the gray area, while a judge who believes in minimal interference of the State into family life might require proof of considerable measurable harm to a child before he or she would be willing to say that the child was abused or neglected.

One final variable that enters into the definition is *time.* The definition may change depending on whether the deviant parenting is seen as episodic or chronic. In either case, it is important to remember that any assessment captures the caretaker at one point in time, and does not reflect the myriad of changes that may take place in the family in the space of a year, a month, or even a few days.

In terms of the actual behaviors defined under the heading of child abuse and neglect, *abuse,* be it physical, sexual, or emotional, is an *active* form of conduct whereby the child is injured by the actions—intentionally or not—of the caretaker; *neglect,* which might be physical, emotional, or the result of lack of supervision or abandonment, is a form of passive conduct whereby the child suffers due to the omissions of the caretaker. Much of the discussion which follows makes the assumption that the basic dynamics of child abuse and child neglect are the same; it is the manifestations which differ.

Emotional abuse and neglect present a particularly difficult definitional problem. Some parenting practices performed in ignorance but in good faith may have emotionally abusive effects. Should the definition therefore be based on parental intent to injure the child, or on the observation of actual injury? It seems necessary to provide a two-level definition, the lower allowing identification and intervention with the offer of services, and the higher serving, if necessary, to force parents to accept help or face the termination of parental rights in cases of severe present or inevitable emotional damage to the child.

In spite of these problems, all States have enacted legislation defining child abuse and neglect and providing for intervention when it is discovered. While the definitions used in these State laws vary, often falling short of useful operational definitions, their significance is great. While various observed or inferred behaviors may be used as the basis for initiating contact with the alleged abusive or neglectful family, the legal definitions provide the mandate for enforcing society's standards of child care on parents and caretakers.

Most definitions of child abuse and neglect focus on children whose "physical or mental health or welfare is harmed or threatened with harm by the acts or omissions" of their parents or other persons responsible for their welfare. (Draft Model Child Protection Act)

INCIDENCE

Given the above-mentioned problems associated with defining child abuse and neglect, it is obvious that reports of incidence from different States will vary widely. Since States also differ in their reporting practices (e.g., lumping abuse and neglect together versus counting each separately) and many cases of child abuse and neglect are never reported, either because they never come to anyone's attention or because the professional who does become involved neglects to report the case to the mandated agency, attempts to compile these reports on a national basis necessarily yield estimates rather than hard data.

One of the most detailed of recent studies was conducted by the Children's Division of the American Humane Association, which analyzed a sample of 100,000 reports of abuse and neglect. Their findings showed, among other things, that boys are abused about as often as girls, that women were responsible for the maltreatment in 60 percent of the cases, and that although child abuse and neglect is known to exist in all racial and ethnic groups and all levels of society, lower income families, which are more visible to reporting agencies, are overrepresented in the reports. The AHA also found that while child abuse and neglect affects children of all ages, fully half of the reports concern children under age six. This is particularly significant since the physical consequences of abuse and neglect are more crucial for younger children: Nearly 60 percent of fatalities reported in the study were of children under age two.

Estimates of the total number of abused and neglected children in the United States per year vary widely. Published estimates have ranged from a low of 41,000 cases of abuse (plus six times that number of cases of neglect) to a high of 4.07 million. It should be noted that the low estimates tend to be based on reports, or substantiated reports; when one considers how many cases may go unreported for each one that comes to the attention of the authorities, it becomes clear that the minimum estimates are far below reality.

After careful study of a number of surveys, the National Center on Child Abuse and Neglect has concluded that the figures of 200,000 cases of physical abuse and 800,000 cases of neglect represent a conservative middle ground estimate. To this must be added an estimated 60,000 cases of sexual abuse and molestation, and an unestimated number of cases of emotional abuse and neglect. Also unestimated but of great concern is the number of children—boys and girls—whose youth, attractiveness, and innocence are exploited in the child pornography market, and the probably very large number who are economically exploited for commercial interests, in violation of child labor statutes and the best interests of children's physical and mental health. This totals more than a million maltreated children, of whom perhaps 2,000 or more will die each year as a result of their caretakers' abuse or neglect.

It should be noted that most of the surveys from which these figures were derived were concerned with child abuse and neglect occurring in the home setting, and thus do not begin to consider the incidence of institutional abuse and neglect which is perpetrated against children who are cared for in residential settings, such as group homes and residential treatment centers.

THE PSYCHOSOCIAL ECOLOGY OF CHILD ABUSE AND NEGLECT

Understanding is the first step towards helping, so it is important for professionals and laypersons alike to have some idea of the reasons for the occurrence of child abuse and neglect in families. There are several points of view on why child abuse and neglect happens. These include: psychopathology of the parent, family system dysfunction, the idea that violence—in or out of the family—is "as American as apple pie," and the effects of such social problems as poverty, poor housing and racism. As might be expected, the first reason is generally espoused by psychiatrists, the second by family therapists, and the last two by people active in social policy analysis. One's point of view, past experience, and professional training tend to influence the type of data one collects, and thus the "cause" which one's research discovers.

What emerges from this multiplicity of views is the fact that child abuse and neglect are multidensional behaviors and several factors impinge upon the disturbed parent-child situation. We can avail ourselves of a variety of intervention approaches, so as to refine help efforts to meet the unique needs of the individual family.

Recognizing the existence of multiple, interacting "causes", we will avoid the idea of causation altogether, since it is clear that many families have what might be termed "causes" leading to child abuse and neglect but are still strong and loving. It seems more appropriate to discuss the total psychosocial ecology of the family, i.e., the personal, immediate environmental, social, and cultural backgrounds which influence the interaction of family members with one another.

This approach rejects a narrow examination of one person's behavior—the caretaker's—in favor of a consideration of the interactions within the family system. Although abuse and neglect is sometimes perpetrated on infants even before interactions can begin, researchers in child development and family dynamics are recognizing more and more the reciprocal nature of the parent-child relationship; often children are not passive receivers, but also, by their behavior and attributes, influence the behavior of their caretakers.

The variety of factors which influence total family interaction might be divided into those internal to the family and its members and those acting on the family from outside. One of the most often (though not necessarily best) researched of the internal factors is the psychological profile of the abusive parent. While there is little evidence to suggest that abusive parents are psychotic (current estimates are that perhaps 10 percent may be) or are accurately described by traditional categories of behaviors, certain characteristics are common: emotional immaturity, low frustration tolerance leading to aggression, and rigid thought and behavior patterns.

Other characteristics of parents which might predispose them to abuse and neglect are poor physical health, low intelligence, and negative past family life histories. A majority of identified child abusers relate a history of emotional deprivation as children. This finding may be looked at in several ways. Psychodynamically, it is possible that their treatment as children left them with deep psychic scars and unconscious conflicts, which are acted out against their children, who take on unconscious symbolic significance. Behaviorally, these parents have had no experience with positive parenting enabling them to learn its performance. They may believe, in fact, that what others consider physical or emotional abuse or neglect is a good system of parenting. From the standpoint of need fulfillment, these parents rarely, if ever, experienced a time when they were loved and nurtured; in effect, they may have been robbed of their childhoods, and as adults may be demanding the unconditional love and acceptance from their children that they never received from their own parents. These perspectives should be seen as complementary, not conflicting.

Children are also recognized as active agents in the family. In spite of our cultural myths, no child is sweet, innocent, and pleasant to be around all of the time, and some rarely are satisfying companions. Children with congenital or acquired physical or behavioral traits which make them different or especially difficult to care for are at risk. A child who rejects attempts to provide nurturance (e.g., in cases of physical problems like colic) may be assaulting a parent's already shaky self-concept. Such a parent in such a circumstance may retaliate with maltreatment.

It is also possible for the family to be perfectly healthy as individuals but to interact in a dysfunctional way. The dysfunction may be between parent and child, or between the adult partners, in which case the child may be injured accidentally or purposefully because of resemblance to or association with one of the partners. Increasing attention is being paid to this concept of the family as an interacting system in which all members have effects on each other.

In addition to the physical and mental attributes of the family members, each person's set of values, beliefs, and assumptions also influences his or her interactions with others. Beliefs about the value of children, the age at which certain behaviors can realistically be expected, and ideas about dealing with frustration can determine whether a given interaction ends in rational problem-solving or physical assault.

Environmental factors act on the family at two levels: first and most immediate, the family's specific life situation in terms of its financial status, housing, employment picture, social integration, family relationships, and general stress level; and second, the general community welfare, including both cultural values and assumptions and social institutions.

Financial pressure on the family can be a stress leading to child abuse and neglect, but since maltreatment appears at all income levels and is not ubiquitous among the poor, it would be inaccurate to state that poverty "causes" child abuse and/or neglect.

Unemployment also correlates highly with child abuse and neglect. There is also some indication that unemployment affects child abuse by eroding the self-concept, especially for men, whose social role is viewed by many as material provider for the family by working.

Abusive and neglecting families have also been found to be isolated from other families and from their own extended families. This isolation may be a function of lack of such resources as a car, a telephone, or of geographic isolation—simply living "way out in the country." However, the parents may find themselves isolated in the middle of a crowded urban neighborhood because of their own or their neighbor's personalities. They might even be shunned because of the way they treat their children.

A final aspect of the environment is the occurrence of significant changes in the family's life situation, such as death, getting or losing a job, or moving. The cumulative effect can be an erosion of the strength of the family by robbing family members of needed consistency and stability. Conflict, resulting in abuse and neglect, may follow.

In addition to the internal and immediate environmental influences on the family, the community's values and beliefs about children and parents have an effect on how parents see themselves and their children. In most cases these beliefs are so ingrained that they are never examined or questioned, merely accepted. Some of these assumptions that create hazardous conditions for children are those which state that parents own children as chattel and therefore may do anything they want with them, that adults should rule and children must instantly do what is expected of them (even if it is not stated overtly), and that children need physical punishment to develop "discipline" and respect for authority. Common expressions that exemplify these beliefs are: "You can't tell me how to raise my child"; "When I say 'jump', my kids say 'How high?' on the way up"; and "Spare the rod and spoil the child."

The community, especially the media, creates expectations of what children "should" be like. If children conform to these expectations, there may be no problem, but if not, they are at a risk as "bad kids." Some of these expectations and images are physical, such as the familiar baby in the baby food advertisements who is always smiling and gurgling pleasantly, never squalling or spitting up, never dirty or disagreeable. Others are more behavioral, such as the belief that children exist to gratify their parents, should react appropriately to nurturance, and should develop in ways parents approve.

Children who fail to live up to these expectations—unrealistic or not—may be seen by their parents as "strange," "difficult," "problems," or simply as "rotten kids." This sort of judgment has the effect of not only straining relations between child and parent but of also providing a rationalization for abuse or neglect. For example, the parents might see the child as impossible to care for and therefore deserving severe neglect. Or a particularly rigid parent might see evidences of "evil" in the child that seem to call for extreme levels of punishment, in the name of the child's own good.

Community values and expectations also fall on the parents. As mentioned above, the male who cannot provide for his family is often under stress from role failure, but a woman may also experience dissonance from her role as mother. Although "motherhood" is supposed to be noble, the prevalence of such statements as "She doesn't work," "She's only a housewife," and "She's tied to the kids all day" belie the community's view of a woman who spends all or most of her time caring for her own children. Her realization that what she does—perhaps all she knows how to do—commands so little respect from the community can certainly affect her valuation of herself and her children.

The mass media are particularly able to establish community norms and expectations. As mentioned above, media images of children are overwhelmingly positive and pleasant, which may be a stark contrast to the realities which face parents. Parental uneasiness may be increased by media representations of themselves—pleasant, all-knowing people who rarely, if ever, need to resort to raising their voices at their children, let alone striking them. When at-risk parents—or even normal parents—compare their own behavior to that of these one-dimensional stereotypes, they are almost certain to seem inferior and "bad parents," thus adding one more stress to those they already bear.

The media also play a great part in perpetuating our society's acceptance of violence. Violence is seen as a viable means for removing an obstacle or competitor and for ensuring that one gets one's way. Americans begin their immersion in violence at an early age, with exposure to television, films, and contact sports. The nightly news delivers a heavy dose of crimes against persons, of wars, and of atrocious killings in the name of various causes.

Violence towards children, however, is not a recent development blamable on television violence. Historical records make it clear that as long as adults have cared for children some have mistreated their offspring. Corporal punishment is a tradition, sanctioned by history, personal experience, and even religion: "Foolishness is bound up in the heart of a child; but the rod of correction shall drive it far from him" (Proverbs 22:15); "Withhold not correction from the child; for if thou beatest him with the rod, he shall not die. Thou shalt beat him with the rod, and it shall deliver his soul from hell" (Proverbs 23:13–14).

The final influences on the family unit to be discussed here are social factors—resulting from major social movements or trends—and social institutions—formal, established systems that exist within society.

Three social trends in particular have changed the nature of American family life over the past few generations. These are a shift from rural to urban or suburban places of residence, a shift in family patterns from the extended multigeneration family to the two-generation nuclear family, and a shift in employment patterns from the husband being the sole material provider for the family to a situation with two spouses in paid employment, with children cared for mainly by non-family members.

These changes, in combination with others, have had the effect of isolating the family and depriving it of its past sources of support, as well as placing a new set of stresses on the parents. As opportunities to learn about parenting are severely restricted for many young Americans, they may enter into their own role as parents completely unprepared by their family experience.

The social institutions of a community exert an enormous force on families. A few of these institutions are: the business/commercial system, the religious system, the media, the medical care system (including both public and private caregivers and facilities), the education system, the social welfare system, the social control system (police and courts), and the local/State/Federal governmental triad. Although their effects vary depending on their purpose and on the individual, these systems have an impact on all segments of society.

In addition to the general social institutions which exist in the community and which affect all members of the community, there exists in most areas a set of problem-oriented institutions. These differ from the former in that they generally make contact only with people who are experiencing specific kinds of problems and cease to have direct effects on their lives once the problem has been resolved. Examples of these types of systems include mental health services, child protective services, employment assistance, drug and alcohol rehabilitation, special education, and various types of crisis intervention care.

The purpose of social institutions is to ensure the smooth functioning of the community. Unfortunately, they may have negative as well as positive effects on the functioning of families. Religious institutions, for example, usually serve to strengthen families by teaching values of love and tolerance and by providing support in times of personal and family crisis. An excessively rigid and literal religiosity which encourages the ideas expressed in Proverbs 22–23 (above), however, poses a threat to the safety of children in the family.

The medical care delivery system also has the potential for positive or negative effects. It has the ability to help families not only in terms of its modern techniques of medical intervention, but with the provision of concerned, caring and skillful emotional support. The medical community's tendency toward medical intervention, however, can lead to unnecessary interference, for example in otherwise normal childbirth, to the extent that the bonding process between parents and child—so important for the development of love and nurturing behavior—is sometimes severely disrupted. (The popularization of family-centered maternity care is, fortunately, making some changes in this situation.)

Problem-oriented institutions have a particularly high potential for both positive and negative effects on a family. One important reason for this is their frequent contact with the family when it is in crisis and highly vulnerable to outside effects. Three issues are relevant to this discussion.

First is the question of labelling, and its effect on both clients and the professionals working with them. The diagnosis of "abusive parent" or "psychopathic personality" carries with it not only useful information but also a great deal of emotional weight. To the parent, such a label may be the final, crushing blow to a self-concept which was never very strong and has had to deal with stresses of unemployment, marital strife, and the challenges of child-rearing. For the professional, it may set up a view of the client which is based on the professional's ideas, fears, and biases, not the reality of the person before him or her.

A second issue is the question of clients' self-worth and human dignity and whether or not these are respected by agency procedures and requirements. Can clients ask for help in a dignified, adult way, or are they made to feel inferior by endless retellings of their stories and uninviting or inaccessible physical facilities?

Finally, there is the issue of quality of services. The at-risk parent's hunger for love and nurturance must be dealt with by trained personnel in the proper way, or there is a risk of doing more harm than good.

A few aspects of problem-oriented institutions do cause problems of their own. Abuse and neglect of children by individual caretakers exist in schools, foster homes, residential care facilities, and day care centers. The dynamics are similar to those of the basic parent-child-situation configuration which exists in the family. This phenomenon is perhaps exacerbated by the lack of affectional ties between the caretaker and the child. An agency's policies on the nurturance, stimulation, and discipline of the children in its care, may also be implicated as abusive or neglectful.

PREVENTION

Once the scope of the problem of child abuse and neglect has been recognized, what is an appropriate community response? The obvious general goal is to prevent the maltreatment of children. Prevention may be approached at various levels, each with a specific target and specific methods.

At the most basic level, referred to as tertiary prevention, (or "treatment") the goal is to disrupt an ongoing pattern of abusive or neglectful behavior and to provide assistance or treatment so that it does not recur. The next level, secondary prevention, seeks to avert abuse and neglect within a family that has been defined as high-risk by behavioral or demographic indicators but in which there has not been any overt maltreatment. Primary prevention, the highest level, is geared towards making our society a more supportive place to raise children, and applies not merely to high-risk families but to all adults who care for children.

In terms of actual intervention, the approaches for secondary and tertiary prevention are often the same. As mentioned earlier, the specific approaches vary with the orientations of helping professionals' views of the dynamics of the problem.

One widely-used modality is individual psychotherapy for one or both parents. Less often, the child also receives remedial services. The working assumption is that the maltreatment is in part due to intrapsychic conflicts within the parent which are acted out against the child, or which predispose the parent to resolve parent-child conflicts through violence.

Another approach assumes that the problem is a deficit in parenting skills and responses, and seeks to remedy this deficit through the use of behavior modification methods and educational techniques. Support for this method comes from observations that abusive and neglectful parents were often mistreated themselves as children and therefore have learned inappropriate parenting skills and never been exposed to models of appropriate nurturance. In addition to changing the dysfunctional behavior of the parent, behavioral intervention can also help the parent to learn alternative techniques for influencing the behavior of the child without resorting to violence.

A third treatment modality, family therapy, makes the assumption that the problems lie not within the parent or the child, but in mutual interaction within the family system. Working with the family as a group, the family therapist recognizes that the behavior of individual members of the family affects the functioning of the family as a whole. This is not a modality generally used with a family with small children.

Two other modes of intervention proceed from different bases. In the first, the role of the helping professional is to strengthen the family's ties to the community. These might be with problem-oriented institutions in the community—such as homemaker services, employment assistance, rehabilitation, welfare agencies—for concrete resources of their own. An excellent example of this, now no longer informal, is Parents Anonymous, whose members provide support for each other in times of stress. Or the linkage might be to comprehensive services from the community, which include medical care through hospitals or public health clinics, day care, crisis intervention services, and various kinds of supportive services within and outside the home.

A final modality of individual treatment works from the dual observations that abusive and neglecting parents often experienced significant emotional and/or physical maltreatment themselves as children and tend to be isolated and friendless as adults. The assumption is that deprivation of nurturance caused these parents to "miss" their own childhoods, leading them to expect their children to give them the unconditional affection they never received and rendering them incapable of creating friendships with other adults. The helping persons, often volunteers, play dual roles by serving as friends to the parents and "reparenting" and resocializing them into appropriate roles.

In most communities, the main responsibility for the coordination, if not the provision, of secondary and tertiary prevention services rests with the child protective service (CPS) agency. This is often a part of the State department of public welfare/social services/human resources. CPS has a legal mandate to accept referrals of suspected abuse or neglect, to initiate investigations, and to determine whether reports are founded. If a report is substantiated, depending on the circumstances discovered, CPS is also mandated to provide appropriate services or to initiate the court proceedings for removal, according to agency determination of the best interests for the health and safety of the child.

The aspect of CPS that distinguishes it from most other social services is its involuntary nature; that is, parents do not have the right to reject intervention. For many, this results in a perceived conflict between the rights of the parents and rights of the child. Our society has determined, however, that the right of the child to live in health and safety is important enough to justify legal intervention into the home. This does not mean, however, that the majority of parents must be coerced into accepting help; many, if not most, parents are so uncomfortable with the degree of discord within their families that they welcome the offer of assistance in order to change.

CPS is often in many ways more a coordinator than a provider of services. To begin with, the decision to remove a child against parental wishes can never be made by CPS, but only the court, with legal representation provided to both child and parents. The only exception to this is in emergency cases, and even then the court must review the case as soon as possible. Also, because of the crisis orientation of much of the work of CPS, the agency is in need of a variety of kinds of supports. CPS workers are generally best qualified to carry out the initial parts of the intervention—investigation, determination, and referral—and to supervise the change process, often as ordered by the Court. If therapy is indicated, it is often provided by other agencies, such as public health services and private medical and psychological practitioners, community mental health centers, and other social service providers. In addition to these supports, CPS staff need a group that will advocate for them with local decision makers and share with them the tough decisions relating to the maintenance or dissolution of families. In many communities these functions are carried out by a child abuse and neglect advisory board or task force and a treatment team, or one group may take on both responsibilities.

Thus, secondary and tertiary prevention try to strengthen individuals and families by working with them directly. Primary prevention, on the other hand, has as its chief goal the reorienting and sometimes restructuring of society and its institutions to make it more supportive to families. One aspect of this is the eradication of poverty and racism. It is, of course, naive to expect that poverty and racism will be defeated in the near future. It is equally naive to expect that even if they were removed, child abuse and neglect would vanish, since we know that it exists at all income levels and among all ethnic groups, and that some individuals who are hit hardest by the effects of poverty are still excellent parents. In spite of this, efforts to reduce the effects of poverty and racism on individuals and families—perhaps through public assistance programs and civil rights legislation—have great potential for alleviating some of the major stresses on parents.

There is a need to explore and define the basic needs of families so as to encourage the adoption of appropriate social policies in the full range of social institutions. A tentative and by no means exhaustive list of these might include encouraging the business community to provide for full and satisfying employment, demanding the media present realistic expectations for children and parents, devoting more attention to education for parenthood, asking the medical establishment to move towards family-oriented and self-sufficient health care, especially during the perinatal and early childhood periods, and orienting the social welfare delivery system toward the adoption of policies which promote family unity and achievement, not dissolution and apathy.

There is a law requiring an environmental impact statement before major Federally funded building projects can begin. We have yet to implement a family impact statement before we enact policies that have a bearing on the welfare of families. The Environmental Protection Agency protects our trees; where is the Family Protection Agency to play a similar role for our children and their families?

RESOURCE ENHANCEMENT

Resource enhancement refers to activities designed to strengthen and support the efforts of organizations in serving families.

Activities to enhance resources for preventing and treating child abuse and neglect may take several forms. One of these is the creation and demonstration of new knowledge. Research is ongoing, but there is still much that we do not know, including what types of intervention techniques work best with particular types of clients and client problems. Thus demonstration projects are funded to apply new directions and techniques to specific clients.

A second step in this process is bringing the knowledge to the people who will use it. This is accomplished through training, technical assistance, publications, and consultation. It is often not enough, however, to provide a service agency with information; attitudes of the professionals in the agency or attitudes within the community may need to be dealt with before a change can be made.

Another aspect of resource enhancement is the creation of an atmosphere conducive to interdisciplinary and interagency cooperation. Although few would take issue with a view of child abuse and/or neglect as a multidimensional community problem, it is often necessary for an outside group to lend its specialized talents and techniques for the purposes of establishing coordination and cooperation.

One of the most important tasks in resource enhancement is creation and maintenance of a high level of public and professional awareness of the scope and severity of the problem. It is only through such awareness that professionals will devote their time and energies to dealing with the problem, and the community will underwrite such efforts.

Key targets for awareness efforts are social planners and legislators at both the local and national levels. Making them aware of the problem and the means needed to deal with it helps to ensure the allocation of resources to this area. This is the point where awareness becomes advocacy. It is advocacy for an interest group, but one to which almost everyone belongs—the American family.

RESOURCE PAPER: DEFINING CHILD ABUSE AND NEGLECT

WHY WE NEED A DEFINITION

The words "child abuse" and "child neglect" mean different things to different people. It is important that we have a widely accepted definition of these terms because they describe the situations in which society should and must intervene, possibly against parental wishes, to protect a child's health or welfare. But defining these terms raises the most controversial issues in child abuse and neglect work because they determine the conditions which constitute reportable circumstances and they establish when society, child protective service, and possibly the courts, can intervene into family life.

Definitions of child abuse and neglect seem to many to be both too broad and too narrow. It is difficult to draft legislation which is specific enough to prevent improper application and yet broad enough to cover situations of harm to a child necessitating societal intervention.

For example, while there is broad agreement that the following definition of child abuse and neglect by Professor David Gil describes the concerns most Americans would have for the welfare of children, most would also agree that it would be unacceptably broad and ambiguous for a reporting law, a juvenile court act, or for criminal prosecution purposes.

> [Child Abuse and Neglect is] any act of commission or ommission by individuals, institutions, or society as a whole, and any conditions resulting from such acts or inaction which deprives children of equal rights and liberty and/or interferes with their optimal development. (David Gil, *Violence Against Children*, Harvard University Press, 1973.)

As a result, there are many different approaches to defining "child abuse" and "child neglect." One approach is found in the Model Child Protection Services Act:

EXCERPT FROM THE DRAFT MODEL CHILD PROTECTIVE SERVICES ACT

Section 4. Definitions

When used in this Act and unless the specific context indicates otherwise:

(a) "Child" means a person under the age of 18.

(b) An "abused or neglected child" means a child whose physical or mental health or welfare is harmed or threatened with harm by the acts or omissions of his parent or other person responsible for his welfare.

(c) "Harm" to a child's health or welfare can occur when the parent or other person responsible for his welfare:

  (i) Inflicts, or allows to be inflicted, upon the child, physical or mental injury, including injuries sustained as a result of excessive corporal punishment; or

  (ii) Commits, or allows to be committed, against the child, a sexual offense, as defined by State law; or

  (iii) Fails to supply the child with adequate food, clothing, shelter, education (as defined by State law), or health care, though financially able to do so or offered financial or other reasonable means to do so; for the purposes of this Act, "adequate health care" includes any medical or non-medical health care permitted or authorized under State law; or

  (iv) Abandons the child, as defined by State law; or

  (v) Fails to provide the child with adequate care, supervision, or guardianship by specific acts or omissions of a similarly serious nature requiring the intervention of the child protective service or a court.

(d) "Threatened harm" means a substantial risk of harm.

(e) "A person responsible for a child's welfare" includes the child's parent; guardian foster parent; an employee of a public or private residential home, institution or agency; or other person responsible for the child's welfare.

(f) "Physical injury" means, death, disfigurment, or the impairment of any bodily organ."

(g) "Mental injury" means an injury to the intellectual or psychological capacity of a child as evidenced by an observable and substantial impairment in his ability to function within a normal range of performance and behavior, with due regard to his culture.

THE VARIOUS DEFINITIONS OF CHILD ABUSE AND NEGLECT

In our State and community, there are many different definitions of child abuse and neglect; some are found in laws, some are found in procedures and some are found in the informal practices of those agencies assigned to implement laws concerning child abuse and neglect.

Criminal Law Definition:

In our State, those forms of child abuse and neglect that are criminally punishable are defined by the penal law as follows:

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Juvenile Court Act:

In our State, the juvenile court is authorized to provide protective services and remove children from their parents under the following definition of child abuse and neglect:

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Reporting Law Definition:

In our State, we have a reporting law that requires some persons and permits others to report known and suspected child abuse and neglect. Such a report activates the child protective process which can result in either juvenile court or criminal court action. The definition of child abuse and neglect found in our reporting law is:

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If the above cited definitions are identical, the trainer should note this fact and emphasize the important responsibility placed on those involved in child protective decision-making, physicians, nurses, educators and especially police and child protective personnel, in making the kinds of informal decisions about which track—criminal, child protective or juvenile—that a case should take.

If the definitions differ, the trainer should note this fact and point out how they differ. Most likely, the criminal law definition will focus on specific acts of the parents in such a way as to isolate criminal intent as a reason for prosecution. Most likely, the juvenile court definition will focus on harm to the child as a justification for taking protective steps in relation to that child. Finally, the reporting act will probably describe apparent situations which give rise to sufficient cause for concern ("reasonable cause to believe") to require the investigation of the home situation and the danger to the child by some appropriate investigative agency (generally a child protective service agency of the local department of social services, or the juvenile division of the police department.)

Agencies dealing with child abuse and neglect need definitions that assist them in performing their responsibilities. To guide these professional staff, definitions need to be functional rather than legalistic. Hospitals need definitions for purposes of referring certain types of cases to the "child abuse team" or to the hospital social services department. Medical definitions tend to stress serious injury, which physicians can detect during an examination of a child. Social work definitions focus on serious problems of family dysfunction. For example, they frequently identify physical abuse as any nonaccidental injury in order to intervene rapidly and prevent serious harm to the child. They believe that abuse, regardless of its degree of severity, is part of the parent-child relationship and should be attended to, the earlier the better. Because intervention by a social work agency is often voluntary (with the family's consent), a social work definition of abuse or neglect may not describe either an act of omission of a parent or harm to a child as specifically as a legal definition must.

The definition(s) of child abuse and neglect found in our agency's (or agencies') regulations is/are:

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CHILD ABUSE AND NEGLECT: AN AMERICAN CONCERN

NARRATION	**ILLUSTRATION**
(Music begins, nursery rhyme type)	**1. Focus—Begin audio here**
	2. We Can Help—National Center on Child Abuse and Neglect, Children's Bureau
	3. Black slide
/4/CV: There was an old woman who lived in a shoe. She had so many children she didn't know what to do.	**4. Storybook drawing**
/5/She gave them some broth without any bread.	**5. Interior of shoe, kitchen**
/6/And whipped them all soundly and sent them to bed.	**6. Hallway, mother and kids**
*MV: /7/*We all know this nursery rhyme; it has been a part of our culture for years. We say it, and teach it to our children, and never think much about it.	**7. Father reading to two children**
/8/But it may be more meaningful than we think. It may tell us something about parents . . . and children.	**8. CU of father reading**
*CV: /9/*There was an old woman . . .	**9. MS mother hanging clothes**
/10/FV: Or a young woman, or a couple, or a man . . .	**10. Combined illustration**
*CV:/11/*Who lived in a shoe.	**11. Mother bringing in wash**
*MV: /12/*Or a shack, or a tenement, or a condominum.	**12. Combined illustration**
*CV: /13/*She had so many children . . .	**13. Kitchen, children everywhere**
*FV: /14/*Sometimes women may not know how to keep from having children, or some may feel they "need" them . . .	**14. Mother cooking holding baby**
*CV: /15/*She didn't know what to do.	**15. Mother picking up crying child**
*MV: /16/*Sometimes parents don't know how to cope with being poor, or alone, or having few resources, or just with being a parent. And it's worse if they have no friends or family to depend on.	**16. Father ignoring child**
*CV: /17/*She gave them some broth without any bread . . .	**17. Mother putting food on table**
*FV: /18/*Not very nourishing, but sometimes parents can't afford any better, or may not know what kids need to grow.	**18. Child toying with food**
*CV: /19/*And whipped them all soundly and sent them to bed.	**19. Mother whipping child**
*FV: /20/*And if one child is fussy or difficult, and cries, then some of a parent's frustrations may be expressed in the whipping . . .	**20. Mother spanking child**
/21/This is child abuse and neglect.	**21. CU child drying tears**
(Music—instrumental, slightly upbeat, middle-of-road)	**22. Title:** *Child Abuse and Neglect: An American Concern*

CV = child's voice; FV = female's voice; MV = man's voice; CU = Closeup; OS = Over the shoulder; MS = Medium shot.

	23. Credits
	24. Credits
*MV: /25/*What is child abuse and neglect? According to Public Law 93–247, the Child Abuse Prevention and Treatment Act,	**25. CU crying child sitting on front step**
/26/". . . child abuse and neglect" means the "physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18 by a person who is responsible for the child's welfare."	**26. Graphic: drawing w/copy summarizing definition**
*/27/*Harm can occur through inflicted physical or mental injury */28/* sexual offenses—rape or molestation,	**27. Hurt child** **28. Withdrawn 12-year-old girl**
*/29/*failure to provide adequate food, clothing, shelter, education, or health care,	**29. Hungry child**
*/30/*abandonment or lack of adequate supervision, or exploitation.	**30. Children on street corner**
*FV: /31/*This harm may come from a parent, but child abuse and neglect is found not only in private residences, but also in foster homes and residential institutions, juvenile detention facilities, and schools; in any setting, in fact, where children are being cared for.	**31. Children in classroom**
*/32/*How extensive is the problem? Unfortunately, we don't really know.	**32. Focus on faces from 31**
*/33/*The failure of some professionals to report suspected cases and differences in State definitions of child abuse and neglect and reporting procedures leaves us with an incomplete picture.	**33. Pediatrician examining child**
*MV: /34/*The Children's Division of the American Humane Association has analyzed a sample of 100,000 cases of child abuse and neglect reported in 1976. The study found that boys are abused as much as girls, child abuse and neglect affects children of all ages, and as many children die from neglect as abuse. Children under two years of age comprised nearly 60 percent of all fatalities. Lower-income families have a higher visibility to agencies which report child abuse.	**34. Graphic, children and copy**
*/35/FV:*But child abuse and neglect occurs at all income levels and among all ethnic groups. The study found that women were responsible for the abuse or neglect in 60% of the cases, possibly because women spend much more time with children than men do. More than half of those people who abused or neglected children were over thirty years of age.	**35. Graphic: parents**
*/36/*But reported cases tell us only part of the story of child abuse and neglect. The National Center on Child Abuse and Neglect estimates that about 200,000 children are abused annually and that four times that number are neglected every year. That's one million mistreated children.	**36. Graphic w/stats**
*/37/*About 2,000 of these die as a result of their maltreatment.	**37. Graphic**
MV: */38/*What are the effects of child abuse and neglect? The grimmest effect, of course, has just been mentioned: the loss of 2,000 young lives every year.	**38. Graphic: broken doll**
*/39/*In addition, child abuse and neglect can result in bruises, broken bones, blood clots, brain damage, blindness, deafness, malnutrition and long-term physical disabilities.	**39. Montage**

57

*/40/*And damage is not limited to the physical level. Abused and neglected children often suffer emotional distrubances and learning retardation, and are frequently socially handicapped.	**40. Withdrawn child**
*/41/FV:*But the most insidious effect is that children robbed of their childhood by their parents' inability to provide safety and nurturance often grow up */42/*unable to be adequate parents *themselves*, thus perpetuating the cycle of abuse and neglect.	**41. Parent striking child** **42. Grown child**
*/43/*What causes child abuse and neglect? The problem is too complex to point to one cause. Instead, we can more realistically discuss its psychosocial ecology, that is, the characteristics of the human environment which have an impact on the family.	**43. Child in bed**
*MV: /44/*Today families come in all shapes and sizes. There are single parents, foster parents, and adoptive parents. There are nuclear families, extended families, and even families where nonrelated adults live within the same household.	**44. Montage of families**
*/45/*But whatever the composition of the family, there are many influences that can play a role in child abuse and neglect. There are two kinds of influences on family interaction: personal factors and environmental factors.	**45. Graphic: personal and environmental factors**
*/46/*Personal factors include personal capacities and personal attitudes. */47/*Environmental factors include specific life situations and the general community welfare.	**46. Graphic: personal factors** **47. Graphic: environmental factors**
*/48/*Personal capacities include the caretakers' physical health, mental health, intelligence, and past family history, all of which can affect the ability to meet the challenges of parenting.	**48. Graphic: personal capacities**
*/49/*Although psychotic, severely neurotic, or severely retarded parents may place their children at risk, most abusive and neglectful parents are *not* mentally ill, /50/ and mild-to-moderately retarded people can be excellent parents.	**49. Parent yelling** **50. Couple w/children**
*MV: /51/*The parenting that caretakers received in their own childhoods seems to have a crucial effect on their personal capacities.	**51. Child alone in bed**
*/52/*If they were abused or neglected as children, if they did not receive adequate nurturance and parenting, if their childhood was "missing" because of unmet dependency needs,*/53/*they may lack the know-how and ability to provide good parenting. First, Having never experienced it, they may simply not know what good parenting entails.	**52. Child alone** **53. Father with child in playpen**
*/54/*Second, they may expect their unmet needs for love and nurturance to be met by the child in their care.	**54. Parent reaching out**
*/55/*Third, they may not have had a chance to develop the strengths a parent needs to stand up to the stresses of life.	**55. Worried parent**
*/56/*In addition to physical and mental attributes, caretakers' personal values and beliefs also influence interactions with children. Particularly relevant are ideas about violence, the value of children, expectations-realistic and unrealistic—and how to handle frustration.	**56. Graphic: personal attitudes**
*FV: /57/*An equally important ingredient can be environmental factors.	**57. Graphic: environmental factors**

*/58/*Specific life situations can create intolerable stress: situations such as financial pressures (which can occur at both high and low income levels), poor housing and unemployment, which can prevent a parent from fulfilling his or her usual role.	**58. Graphic: specific life situations**
*/60/*Relationships with family members and others outside the family are also factors.	**60. Family group**
*/61/*Parents who by temperament, geography, or lack of resources are socially isolated from neighbors and extended family lack the network of *people resources* that they need.	**61. Montage**
*/62/*Their vulnerability can be magnified by couple relationships characterized by lack of support and refusal or inability to meet emotional needs.	**62. Couple quarreling**
*MV: /63/*If conflict or resentment is present, the child may be injured because of his or her resemblance or association with the other adult partner. */64/*The child's own characteristics may contribute to abuse and neglect situations. A child seen as different or difficult to care for faces greater risks—for example, children with physical or mental handicaps, or children who are constantly sick or who respond poorly to nurturing.	**63. Child listening**
*FV: /65/*Also, a child who resembles or symbolizes a parent's past or present personal conflict is particularly vulnerable.	**65. Parent shaking child**
*FV: /66/*A surprising number of maltreated children were wanted at birth—some desperately so. But many may not have turned out to be *what* was wanted.	**66. Parent with baby**
*MV: /67/*The general community is another force influencing family life—its values and its institutions may create a climate that accepts, even condones child maltreatment. */68/* Our literature—even the Bible—overtly and covertly encourages physical discipline of children. */69/*Our mass media promote expectations of the "perfect" baby-cute, quiet, never dirty or disagreeable.	**67. Graphic: general community welfare** **68. Books** **69. Baby on rug**
*/70/*And our national fascination with violence leads parents to use it to try to solve problems.	**70. Parent about to hit**
*FV: /71/*Additionally, social and institutional factors may intensify the situational stress or the personal crisis of the parent or caretaker.	**71. Parent with child at school**
*/72/*The policies of the business, religious, media, medical, educational, and social control systems of the community influence the ability of the caretakers to provide proper nurturance to children, and they *can create* many kinds of physical and emotional stress.	**72. Worried man**
*/73/*Problem-oriented institutions such as departments of public welfare, child protective services and community mental health agencies may act to relieve stress, */74/*but may also add stresses of their own, such as the anxiety which accompanies being labelled "an abusive parent," or, "a person in need of therapy."	**73. Montage/agencies** **74. Caseworker with parent**
*MV: /75/*Social institutions can also be settings for abuse or neglect. The only institution that can use corporal punishment is not the penal system, nor the Armed Services, but the public schools.	**75. Teacher, child**
*/76/*And surely average monthly public assistance grants of less than $60 per child are indicative of a neglecting attitude on the part of our society as a whole.	**76. Mother at mailbox**

*FV: /77/*How can we help abusive and neglecting families to cope? One approach focuses on families in which an actual incident or a strong risk of child abuse or neglect has already been identified. The intervention might focus on individual caretakers, through counseling to reduce emotional stresses.	**77. Caseworker**
*/78/*Or it could take the form of teaching coping skills and providing information on child development.	**78. Child care class**
*MV: /79/*Programs in many States are using parent self-help groups and volunteers to help parents meet their dependency needs through "reparenting," resocialization, and role modeling.	**79. Parents in meeting**
*/80/*Concrete assistance and resources such as homemaker services, financial assistance, and employment programs can help relieve stresses on parents.	**80. Montage**
*/81/*The child might be the focus of specific treatment to modify certain behaviors.	**81. Child with caseworker**
/82/ Or the child might be removed for part of the day by being placed in day care.	**82. Day care**
*/83/*A family system-centered approach might focus on helping couples and families to have more satisfying interactions.	**83. Family**
*FV: /84/*Many modalities are possible, but all must consider the cultural and social context of the family, and ensure that services are provided within that context.	**84. Montage**
*MV: /85/*A more positive approach to child abuse and neglect focuses on preventing it before it happens.	**85. Families**
*/86/*Prevention applies to everyone, not just high-risk families.	**86. Montage**
*FV: /87/*Some prevention efforts focus on children to ensure the full legal, medical, educational, and social services to which they have a right.	**87. Nurse**
*/88/*Specialized crisis hotlines or 24-hour crisis nurseries can help families during acutely stressful situations.	**88. Montage**
*MV: /89/*Other prevention efforts might operate at the institutional level, supporting programs which strengthen families, build their pride, and help them to create human resource networks. Or programs can directly intervene in cases of institutional abuse or neglect.	**89. Montage**
*FV: /90/*The most important objectives of prevention are to emphasize the human worth and rights of the child.	**90. Mother and child**
*/91/*As a citizen and a person, *not* a piece of property.	**91. Safety patrol**
*/92/*And to *downgrade* our culture's tendency to use violence as a first-choice solution to problems and frustrations by encouraging other alternatives.	**92. Father and child**
*/93/*One way to do this is to increase efforts toward full social equality for *all* people.	**93. Montage**
(Music begins again, with closing theme)	
*MV: /94/*Child maltreatment has been with us, for centuries.	**94. 1900's drawing**
*/95/*Currently in the United States, increasing numbers of cases of abuse and neglect are reported every year.	**95. Graphic: face and figures**

*FV: /96/*Child abuse and neglect is obviously not a problem that can be solved overnight.	**96. Child**
*/97/*But mobilizing the entire community to become involved in efforts to identify, treat and prevent child abuse and neglect */98/* is a necessary—and vital—first step toward ensuring all children the nurturance they deserve.	**97. Community PTA meeting** **98. Family**
/99/(pause 6 seconds)	**99. Father reading**
/100/(pause 6 seconds)	**100. Family swinging**
/101/(pause 6 seconds)	**101. CU smiling face**
(Music fades)	**102– 105. Remaining credits**

—END—

PRETEST OR POST TEST

THE QUESTIONS IN THIS INTERVIEW ARE DIRECTED AT VARIOUS ASPECTS OF CHILD ABUSE AND NEGLECT OTHER THAN DIRECT TREATMENT. PLEASE COMPLETE EACH ITEM BY CHECKING THE APPROPRIATE CATEGORY OR FILLING IN THE SPACE PROVIDED. WORDS IN CAPITAL LETTERS, AT THE END OF SOME OF THE ITEMS, ARE SPECIAL INSTRUCTIONS TO YOU. THE ENTIRE INTERVIEW SHOULD TAKE NO MORE THAN 20 MINUTES OF YOUR TIME.

1. In the first three columns of the table below, please rate yourself in terms of your *knowledge* of the various activities related to cases of child abuse and neglect. (BENEATH THE TABLE ARE BRIEF DEFINITIONS OF EACH OF THE ACTIVITIES. CHECK THE APPROPRIATE BOX ON EACH LINE). In the last three columns of the table, rate yourself in terms of your *confidence* to perform the various activities. (CHECK THE APPROPRIATE BOX ON EACH LINE)

Activity	(1) High Degree of Knowledge	(2) Moderate Degree of Knowledge	(3) Little Knowledge	(4) High Confidence	(5) Moderate Confidence	(6) Little Confidence
Identification of Physical Abuse						
Identification of Emotional Maltreatment						
Identification of Sexual Abuse						
Identification of Neglect						
Reporting						
Referral						
Case Management						

DEFINITION OF ACTIVITIES:

Identification means finding and recognizing cases of child abuse and neglect after they have occurred.

Reporting means bringing to official attention cases of child abuse and neglect that have been identified.

Referral means linking families involved in child abuse and neglect with the resources they need.

Case Management means maintaining an on-going involvement with cases of child abuse and neglect throughout the duration of treatment.

2. In terms of your *knowledge* of the following topics related to child abuse and neglect, how would you rate yourself using the table below? (CHECK THE APPROPRIATE BOX ON EACH LINE)

TOPIC AREA	KNOWLEDGE		
	High	Moderate	Little
Reporting obligations of my state law			
Legal safeguards, if any, which protect me from liability			
Procedures for interagency referral of a case of child abuse or neglect			
Procedures to report a case of child abuse or neglect			
Legal definition of physical abuse in my jurisdiction			

3. In terms of your *confidence* to perform the following activities related to a case of child abuse and neglect, how would you rate yourself using the table below? (CHECK THE APPROPRIATE BOX ON EACH LINE)

ACTIVITY	CONFIDENCE		
	High	Moderate	Little
To counsel an abusive (or potentially abusive) parent to accept help			
To assess family needs			
To develop a treatment plan			
To follow through with other persons or agencies			
To prepare for court and court testimony			
To provide court testimony			
To convey information on child abuse and neglect to others engaged in work with abused and neglected children			
To discuss a case of child abuse and neglect with my colleagues			

4. How would you rate your *understanding* of the role the following organizations or individuals in your community *actually* play in regard to cases of child abuse and neglect? (CHECK THE APPROPRIATE BOX ON EACH LINE)

ORGANIZATIONS AND INDIVIDUALS	Good Understanding	Moderate Understanding	Little Understanding
Police department			
Schools			
Day care centers			
Mental health centers			
Hospitals			
Public health departments			
Social service departments			
Private physicians			

5. How would you summarize the reporting obligations of your State law in cases of child abuse and neglect? (IF YOU DO NOT KNOW THE EXACT WORDING, STATE THE REPORTING OBLIGATIONS AS BEST AS YOU CAN USING YOUR OWN WORDS)

____

____

____

6. How would you report a case of child abuse and neglect?

____

____

____

7. What legal safeguards, if any, protect you from liability in such cases?

____

____

____

8. What are the procedures for interagency referral of child abuse and neglect cases in your community?

____

____

____

9. What is the legal definition of physical abuse in your State? (IF YOU DO NOT KNOW THE EXACT WORDING, STATE THE DEFINITION AS BEST AS YOU CAN USING YOUR OWN WORDS)

____

____

____

My State is: ______________________________

10. Does your State law explicitly refer to emotional maltreatment as a reportable form of child abuse?
_____Yes
_____No
_____Don't know

11. There are many physical cues or behavior patterns ("clues") which either suggest the need to examine a case further or to keep track of a case because a potential for child abuse or neglect exists. A list of *possible* "clues" for four categories of child abuse and neglect are presented below. Please identify for each item the one category of child abuse and neglect for which you think it is *most* appropriate. (PLACE THE LETTER REPRESENTING THE APPROPRIATE CATEGORY ON THE BLANK LINE NEXT TO EACH ITEM. IT IS RECOGNIZED THAT FOR SOME ITEMS THERE IS MORE THAN ONE "ACCEPTABLE" RESPONSE)

Physical Abuse **(A)**
Emotional Maltreatment **(B)**
Sexual Abuse **(C)**
Neglect **(D)**
None **(E)**
Do Not Know **(F)**

a. A parent who repeatedly denies a child physical affection or nurturance. **a.**_____

b. Bruises on the face of an infant. **b.**_____

c. Parents who tend to be transient and isolated from family and neighbors. **c.**_____

d. A family which is a culturally isolated group with members seeking satisfaction within the family. **d.**_____

e. A child displaying severe habit disorders, such as, rocking, bed wetting, feeding problems. **e.**_____

f. A child appears emaciated and tends to regurgitate food, then rechews it and reswallows it. **f.**_____

g. A child comes to school in cold weather frequently missing key items of clothing such as underwear, shoes, outer dress. **g.**_____

h. A mother who cannot discriminate her child's needs. h.______

i. A bald, flattened spot on the back of an infant's skull. i.______

j. A child displaying erratic behavior such as moving from overagressiveness to withdrawal. j.______

k. A child who does not show appropriate growth patterns, such as an inability to talk by age three. k.______

l. An adult who is timid, passive and indicates strong feelings of sexual inadequacy. l.______

12. In right-hand column please indicate whether you strongly agree, agree, are uncertain, disagree, or strongly disagree, with the following statements;

a. Parents who physically abuse their children are mostly from lower socio-economic levels. a.______

b. The identification of cases of child abuse and neglect should be handled primarily by individuals who are specifically trained to work with problem families. b.______

c. Children who have suffered abuse or neglect from their parents should be removed from the home permanently to prevent future physical or emotional trauma. c.______

d. Unfortunately, most cases of child abuse and neglect cannot be prevented. d.______

e. All parents can be considered potential child abusers. e.______

f. Unless conclusive evidence of abuse or neglect exists, reporting a suspected case of child abuse or neglect is an irresponsible act. f.______

g. In an interview with a parent suspected of child abuse or neglect, it is important for the social worker, physician, or health professional to focus the interview on the child rather than on the parent. g.______

h. Willingness to report a case of child abuse or neglect can be affected by one's attitudes or feelings toward the family involved. h.______

i. Parents who abuse or neglect their children should be prosecuted to the fullest extent possible. i.______

13. Please complete the following items by checking the appropriate category:
    a. One of the powers of most juvenile courts is the power to terminate parental rights in cases of child abuse and neglect.
    ______Yes ______No ______Don't know
    b. The majority of reported cases of child abuse and neglect do not result in court action. They are either dismissed after evaluation or referral to social services on a voluntary basis.
    ______Yes ______No ______Don't know
    c. Special children—ones who are mentally, physically, or developmentally handicapped—are less likely than other children to be abused by potentially abusive parents.
    ______Yes ______No ______Don't know
    d. Abusive parents are about as likely as non-abusive parents to have been abused as children.
    ______Yes ______No ______Don't know
    e. The majority of States have yet to adopt some type of legislation governing neglected children.
    ______Yes ______No ______Don't know
    f. In a case heard in juvenile court, the judge will decide whether the child has been abused or neglected based only on the evidence presented during the hearing.
    ______Yes ______No ______Don't know
    g. In two parent abusive families, the parents often alternate abusing the child.
    ______Yes ______No ______Don't know
    h. Unless emotional maltreatment is accompanied by physical abuse or gross neglect, there may be no substantiating evidence that would stand up in court as evidence of this maltreatment.
    ______Yes ______No ______Don't know
    i. In general, there is more resistance to recognizing and reporting suspected cases of sexual abuse than other forms of child abuse and neglect.
    ______Yes ______No ______Don't know
    j. Extremely aggressive, demanding, and rageful behaviors are more common in a child who is mildly or inconsistently abused than in a severely abused child.
    ______Yes ______No ______Don't know
    k. Physicians are not permitted to talk with the attorney for parents or the attorney for the child prior to a court hearing on a case of child abuse or neglect.
    ______Yes ______No ______Don't know
    l. Social work or medical records are generally not admissible as evidence during a trial on a child abuse or neglect case.
    ______Yes ______No ______Don't know

14. Before physical abuse can be reported, there must be evidence of: (CHECK ONE)
    ______A—Serious injury to the child
    ______B—Parental intent
    ______A and B
    ______Neither A nor B

15. Which of the following is *not* a primary purpose of the medical or social work interview with a parent in a suspected case of child abuse or neglect? (CHECK ONE)

____To establish rapport with the parent

____To collect sufficient information to determine if the child is in need of protection

____To establish the identify of the abusive parent (or other person)

____To gain information and understanding about the parents and the family situation

THANK YOU VERY MUCH FOR YOUR COOPERATION!

Unit 2: IDENTIFYING THE PHYSICALLY ABUSED CHILD

UNIT 2

Time: 3 hr.
40 min.

IDENTIFYING THE PHYSICALLY ABUSED CHILD

DESCRIPTION OF UNIT:

This unit presents an overview of the identification of physical abuse, including: (1) physical indicators, (2) behavioral indicators, (3) characteristics of parents who abuse their children, and (4) a case study of a suspected incident of child abuse. Participants are encouraged to identify and share their feelings about abused children and their parents.

GOALS:

1. To present information on the physical and behavioral indicators of child abuse in order to help participants learn to make accurate and objective observations.
2. To explore the personal and situational characteristics of parents who abuse their children, in order to help participants gain insight into the individual and family dynamics which produce abusive behavior.
3. To consider a case of suspected child abuse in order to help participants understand and practice the identification process.

OBJECTIVES:

At the conclusion of this unit, participants will be able to:

1. List or select from a list at least five physical indicators of child abuse.
2. List and describe at least four behaviors in a child that may indicate physical abuse.
3. Describe at least two interactions between parents and children that may indicate an abusive situation.
4. List or select from a list at least three characteristics typical of parents who abuse their children.
5. Describe their feelings toward known or suspected abusers and toward children who have been physically abused.

RATIONALE:

This unit is meant to convey factual information about physical and behavioral signs of child abuse in order to help participants who work with children and families recognize those signs. Because recognition is not enough, the unit also attempts to deal with both the context of physical abuse of children, including the needful qualities of their parents, and with the feelings evoked in those who see the signs and must interpret them and take action by reporting their suspicions of child abuse. It is very important that the leader be sensitive to the participants' feelings while working through the activities of this unit. In the final analysis, participants' feelings can effectively block out all of the factual information and render participants incapable of acting responsibly when confronted with an abused child.

ADDITIONAL STAFF NEEDED:

None.

SPACE REQUIREMENTS:

One room large enough to accommodate the total group, with space sufficient to spread out for small groups of 6 to 8 participants and wall space to hang newsprint for taking group notes in Activity 6.

EQUIPMENT:

35 mm. filmstrip projector and cassette tape recorder
16 mm. sound film projector
Screen
Extension cord and adapter plug, if necessary
1 easel and pad of newsprint or easel paper or
Large chalkboard, chalk and eraser
Felt-tip markers
Masking tape

AUDIOVISUALS:

Filmstrip/cassette recording: *"Physical Indicators of Abuse: Signs of Alert"*

Filmstrip/cassette recording: *"Physical Abuse: What Behavior Can Tell Us"*
Film: *"Abusive Parents"*

BEFORE YOU BEGIN:

Duplicate the Thomas Case and any other necessary materials, unless there are sufficient copies of **WE CAN HELP Resource Materials** for each participant. The necessary materials include: 3 resource papers, 1 set of case materials. Be sure you have a copy of the state's reporting law, with the definition of physical abuse identified, for use in Activity 1. *Preview the audiovisuals,* paying particular attention to "Abusive Parents," to decide whether this film can be effectively used with your training group and to note the point in the film at which the first segment ends and the projector is to be turned off for a discussion (see Activity 5).

PARTICIPANTS' MATERIALS:

Resource Paper: *"Physical Indicators of Child Abuse"*
Resource Paper: *"Behavioral Indicators of Physical Abuse"*
Resource Paper: *"Characteristics of Abusive Families"*
Case Materials: *"The Thomas Family"*

ACTIVITY	TIME	MATERIALS
1. Introduction, filmstrip and discussion	30 min.	Filmstrip/cassette recording: "Physical Indicators of Abuse: Signs of Alert"; Resource Paper: "Physical Indicators of Child Abuse"
2. Leader Presentation: Child growth and development	10 min.	
3. Filmstrip and discussion	25 min.	Filmstrip/cassette recording: "Behavioral Indicators of Physical Abuse"; Resource Paper: "Behavioral Indicators of Physical Abuse"
BREAK	10 min.	
4. Group Exercise: Human needs and parents who abuse their children	30 min.	Newsprint, masking tape, felt-tip markers for small groups
5. Film and discussion	60 min.	Film: "Abusive Parents" Resource Paper: "Characteristics of Abusive Families"
6. Case Study: The Thomas Family	55 min.	Case Material: "The Thomas Family"

ACTIVITIES

ACTIVITY 1 INTRODUCTION, FILMSTRIP AND DISCUSSION

30 minutes

Introduce unit goals

The leader introduces the goals of this unit:

- To present information on the physical and behavioral indicators of child abuse in order to help participants learn to make accurate and objective observations.
- To describe the characteristics of parents who abuse their children in order to help participants gain insights into the personal and family dynamics which produce abusive behavior.
- To consider a case of suspected child abuse in order to help participants understand and practice the identification process.

State reporting law definition

The leader then reads to the group the State reporting law definition of physical abuse as background for viewing the filmstrip.

Introduce filmstrip

The filmstrip is entitled "Physical Indicators of Abuse: Signs of Alert." There are some pictures which may be disturbing to some viewers. Participants should be asked to pay attention to the various kinds of physical abuse depicted in the filmstrip presentation.

FILMSTRIP

Show filmstrip (13 minutes)

Discussion:

Discussion (12 minutes) Feelings

The discussion of the filmstrip should begin with participants having an opportunity to discuss any feelings generated by the pictures. Each participant can be asked to share a word, phrase or sentence that expresses her or his feelings after viewing the filmstrip. If feelings of distress are voiced (as they probably will be), the leader can ask for a refinement of these feelings. For example:

Most distressing types

- What type of physical indicator was most distressing to look at?
- Why do you think that type of abuse is more difficult to handle emotionally?

Then the discussion should move to the content of the filmstrip, with these questions:

Indicators and definitions

- In what ways do these physical indicators and "operational" definitions of child abuse help or hinder participants in identifying suspected cases?
- How do these physical indicators fit the State's legal definition in the reporting Act?

Identifying to provide child protection

The leader should focus on any discussion of fears and uncertainties about identifying physical abuse, pointing out that signs that cause suspicion may be the only way that the child protective process is begun. An unwillingness to see and interpret such signs can turn out to be harmful, if not fatal, to an endangered child.

Validate feelings

Participants' feelings should be allowed and validated rather than rebutted.

Resource paper

The leader points out that the resource paper, entitled "Physical Indicators of Child Abuse," on page 23 of **WE CAN HELP Resource Materials,** provides a helpful listing of indicators for participants' future use.

ACTIVITY 2. LEADER PRESENTATION: NORMAL CHILD GROWTH AND DEVELOPMENT

10 minutes

Normal child development context

In order to understand child maltreatment, it is important to view the child and the family from the perspective of what is generally normal in child growth and development. This is especially important in interpreting the behavioral indicators of child abuse.

Basic developmental needs and tasks

What are the basic needs and the basic developmental tasks that all children should be able to have fulfilled in their homes?

Physical needs

Physical needs: Food, clothing, shelter, sanitation, protection from physical dangers in the environment.

Developmental needs

Developmental needs: Basic trust, stimulation, limits and discipline, freedom to explore the environment.

Developmental tasks

Developmental tasks: Learning how to interact.

- To learn it is good to touch and be touched.
- To learn it is good to look at and be looked at. (Note: there are some cultures in which intense eye-to-eye contact is considered disrespectful.)
- To learn to enjoy oneself and one's environment using all the physical senses.
- To learn how to choose among options.
- To learn how to take responsibility for one's own actions.
- To learn how to get one's needs met appropriately.

Family as provider

The proper setting for these kinds of growth in children in our society is the family. We expect parents to be the providers who meet these needs and the guides who lead children in mastering these developmental tasks.

Failure to meet needs and allow for tasks is one aspect of child maltreatment.

One aspect of child maltreatment, beyond the physical damage done, is the effect of the failure to provide the physical safety and the emotional security necessary for these needs and tasks to be fulfilled. The signs of that failure are often apparent in children's behavior. By their actions, they seem to be saying:

What the abused child learns

- Touching hurts.
- Looking is the preamble to being hurt.
- There is no safe choice.
- I'm responsible for everything (I feel at fault, no matter what) so my own actions don't really count.
- The only way to get what I need and want is either to take no chances or to be so aggressively obnoxious that someone has to pay attention.

The next filmstrip looks at behaviors often displayed by abused children as well as behavioral indicators in the interaction between parent and child.

(Material for the preceding presentation was suggested by a lecture of Ray E. Helfer, M.D.)

ACTIVITY 3. FILMSTRIP AND DISCUSSION.

25 minutes

FILMSTRIP

Show filmstrip (14 min.)

Discussion:

Discuss filmstrip (13 minutes)

Compare filmstrip with resource paper

The leader asks participants to look at the resource paper, "Behavioral Indicators of Physical Abuse." While the filmstrip suggests a connection between severe abuse with passive, compliant behavior and mild abuse with aggressive behavior, this theory has been called into question by a number of clinicians who work with abused children. Among them is Dr. Harold Martin, a pediatrician at the University of Colorado Medical Center. The resource paper contains some of his perspective on behavioral indicators.

The main point is that abused children often display *extreme* behaviors, on both ends of the passive-aggressive spectrum.

If the participants have had a chance to read the resource paper, the leader asks questions drawing from both the filmstrip and the paper to underscore the information on behaviors. If participants have not yet read the resource paper, the leader should fill in the discussion with points from the paper.

Discussion questions

The discussion should focus on these questions:

What kinds of behaviors do abused children typically display?

How are these behaviors understandable as ways children have *adapted* to their abusive environments?

What are typical, observable parent-child interactions that suggest possible child abuse?

Are there other explanations for these child behaviors, other than child abuse, that one should consider and investigate?

Discussion summary

The leader should summarize this discussion by pointing out that observation of behavior is important in making decisions about child abuse, both in terms of initial identification (behavior can lead one to suspect abuse) and in terms of later treatment (behavior is an index to what patterns of the parent-child relationship need to be changed).

BREAK

10 minutes

ACTIVITY 4. GROUP EXERCISE: COMMON HUMAN NEEDS AND PARENTS WHO ABUSE THEIR CHILDREN

30 minutes

Develop circle of common human needs

The leader draws a large circle on newsprint or the chalkboard and asks the group, "What are the common human needs of each one of us?" Each participant may be asked to name one need, and the leader writes the need inside the circle, until the circle is filled with words. For example:

(See Figure 1)

What happens when needs are not met

When the circle is full and has a wide variety of common needs in it, the leader crosses out or erases one of the needs (for example, knowledge). The leader asks, "What happens when we take away knowledge? What do we have?" The answer, ignorance, is written outside the circle. The elimination process continues, with a need inside the circle deleted and the result written outside the circle. When the circle is almost empty, the leader stops and points out that the picture before the group now is one way of understanding parents who abuse or neglect their children. The picture may look like this:

(See Figure 2)

This graphic depiction of needful adults in parental roles can help us begin to think about parents who harm their children.

ACTIVITY 5. FILM AND DISCUSSION

60 minutes

It is very important that the leader be thoroughly familiar with this film and determine whether the training group will profit from seeing and discussing it.

Introduce film (2 minutes)

The leader introduces the film by pointing out that the first half involves a panel of women who were, at the time of this presentation to a Parents Anonymous conference, incarcerated in a women's prison for child abuse. They represent the most serious cases of child abuse, because their children died as a result. Participants should listen to them with a view to hearing how they have explained to themselves what they did and the personal needs which they share in their presentations.

Show first half of film (approx. 15 minutes)

FIRST HALF OF FILM, THROUGH THE END OF THE PARENT PANEL DISCUSSION. THEN TURN OFF PROJECTOR FOR DISCUSSION

Discussion:

Discuss film (15 minutes)

The leader first invites the participants to "ventilate" their feelings in response to the panel presentation.

Figure 1

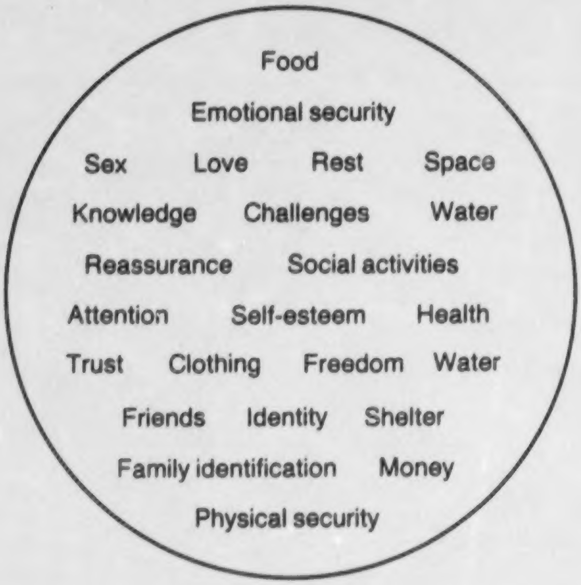
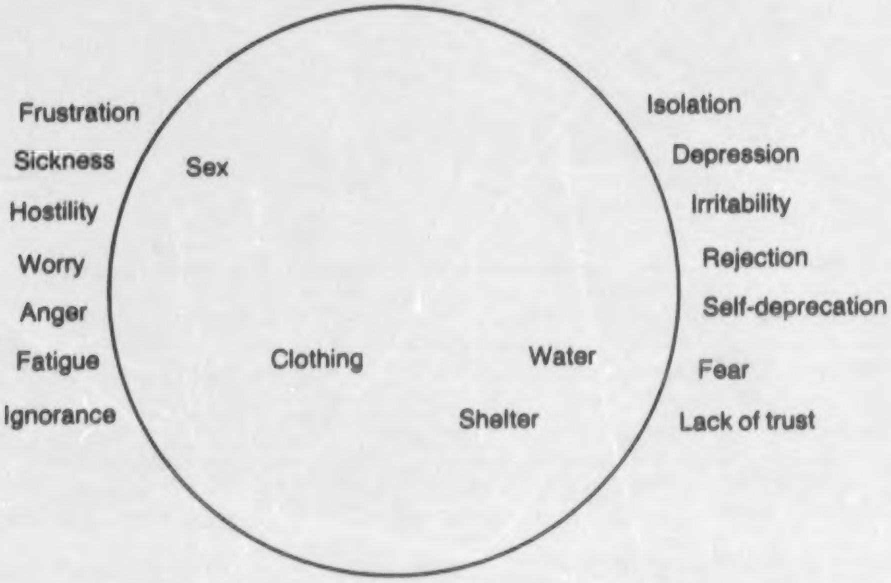

Food
Emotional security
Sex
Love
Rest
Space
Knowledge
Challenges
Water
Reassurance
Social activities
Attention
Self-esteem
Health
Trust
Clothing
Freedom
Water
Friends
Identity
Shelter
Family identification
Money
Physical security

Figure 2


Frustration
Sickness
Hostility
Worry
Anger
Fatigue
Ignorance
Sex
Clothing
Water
Shelter
Isolation
Depression
Irritability
Rejection
Self-deprecation
Fear
Lack of trust

Responses typically range from feelings of empathy and sorrow to outrage at the panelists' attempts to excuse what they did to their children.

List characteristics.

Then, the leader asks the participants to help develop a list of characteristics which they noted in the situations and the personalities of these women. The list can be put on easel paper or the chalkboard.

Introduce second half of film

The leader introduces the second half of the film, in which Elsa ten Broeck, a social worker with experience in providing treatment to parents who have abused their children, discusses the parents in the film.

SECOND HALF OF FILM

Show second half of film (13 minutes)

Discussion:

Discuss characteristics

Following the film, the leader asks participants to add to or disagree with the characteristics presented by Elsa ten Broeck in the film.

ACTIVITY 6. CASE STUDY: THE THOMAS CASE

55 minutes
Introduce exercise (5 minutes)

The leader hands out the Thomas case and discussion questions. The group is divided into small groups of 6 to 8 participants each, with one person appointed as facilitator. Each group will need easel paper, masking tape and a felt-tip marker for taking group notes.

Each group has one member read aloud the first two sections of the case (The Report and the Initial Investigation). Then the participants discuss the material presented using the questions provided as guidance. The facilitator or a recorder can make group notes on the easel paper. After about ten minutes of discussion, the next section (The Background) is read aloud, and the discussion continues using the next set of questions. After another 10–15 minutes discussion, the group reconvenes together to share findings.

DIVIDE INTO SMALL GROUPS

Small group case study exercise (30 minutes)

(The leader should announce times for moving to the next section and give warning when 5 minutes are left for the small groups to complete tasks.)

Small group reports (15 minutes)

When the whole group has reconvened, facilitators present brief reports of their small group findings, addressing these points:

- Physical indicators of abuse,
- Behavioral indicators of abuse,
- Parental characteristics, and
- Suggested services for the Thomas family. (including whether court action is recommended).

Leader's summary (5 minutes)

The Thomas case was deliberately chosen because it is not an easy, open-and-shut case. It is a situation involving excessive discipline, and the intervention does disclose significant family problems and raises questions about the Thomases' ability to provide appropriate nurturance for Mari and Peter, Jr. The group may not reach consensus about what should be done or even whether this situation should be labelled "child abuse." In summarizing, *it is very important* that the leader underscore the appropriateness of the neighbor's decision to call Child Protective Services to alert the agency to the possibility of child abuse, whether or not subsequent investigation confirmed the neighbor's suspicion. A determination of the children's safety in this home and the opportunity to offer help to the Thomases depended on the neighbor's decision to report *suspected child abuse.*

In this case, the Thomases were not brought before the juvenile court. They accepted and followed up on a referral to receive counseling and to join a "positive parenting" class offered by the local YMCA. They voluntarily accepted weekly follow-up contact with a worker assigned by the Child Protective Services agency, which continued about three months until the case was officially closed.

ACTIVITY 7. LEADER'S SUMMARY OF THE UNIT

5 minutes

Summarize material

The leader briefly summarizes the points covered in this unit, noting:

- The state reporting law definition,
- The physical indicators of child abuse,
- The behavioral indicators of child abuse,
- The characteristics of parents who abuse their children, and
- Learning points which came out of the case study exercise.

Announce next session

The leader announces the time and place of the next training session and the unit of material which is to be covered.

RESOURCE OUTLINE
PHYSICAL INDICATORS OF ABUSE

A. Bruises and welts that may be indicators of physical abuse:

1. Bruises on any infant, especially facial bruises.
2. Bruises on the posterior side of a child's body.
3. Bruises in unusual patterns that might reflect the pattern of the instrument used, or human bite marks.
4. Clustered bruises indicating repeated contact with a hand or instrument.
5. Bruises in various stages of healing.

B. Burns that may indicate abuse:

1. Immersion burns indicating dunking in a hot liquid ("stocking" burns on the arms or legs or "doughnut" shaped burns of the buttocks and genitalia).
2. Cigarette burns.
3. Rope burns that indicate confinement.
4. Dry burns indicating that a child has been forced to sit upon a hot surface or has had a hot implement applied to the skin.

C. Lacerations and abrasions that may indicate abuse:

1. Lacerations of the lip, eye, or any portion of an infant's face (e.g., tears in the gum tissue which may have been caused by force feeding).
2. Any laceration or abrasion to external genitalia.

D. Skeletal injuries that may indicate abuse:

1. Metaphyseal or corner fractures of long bones—a kind of splintering at the end of the bone (these are caused by twisting or pulling).
2. Epiphyseal separation—a separation of the growth center at the end of the bone from the rest of the shaft (caused by twisting or pulling).
3. Periosteal elevation—a detachment of the periosteum from the shaft of the bone with associated hemorrhaging between the periosteum and the shaft (also caused by twisting or pulling).
4. Spiral fractures—fractures that wrap or twist around the bone shaft (caused by twisting or pulling).

E. Head injuries:

1. Absence of hair and/or hemorrhaging beneath the scalp due to vigorous hair pulling.
2. Subdural hematomas—hemorrhaging beneath the outer covering of the brain (due to shaking or hitting).
3. Retinal hemorrhages or detachments (due to shaking).
4. Jaw and nasal fractures.

F. Internal injuries:

1. Duodenal or jejunal hematomas—blood clots of the duodenum and jejunum (small intestine) (due to hitting or kicking in the midline of the abdomen).
2. Rupture of the inferior vena cava—the vein feeding blood from the abdomen and lower extremities (due to kicking or hitting).
3. Peritonitus—inflammation of the lining of the abdominal cavity (due to a ruptured organ, including the vena cava).

G. Injuries considered to be indicators of abuse should be considered in light of:

1. Inconsistent medical history.
2. The developmental abilities of a child to injure itself.
3. Other possible indicators of abuse.

H. Questions to ask in identifying indicators of abuse:

1. Are bruises bilateral or are they found on only one surface (plane) of the body?
2. Are bruises extensive—do they cover a large area of the body?
3. Are there bruises of different ages—did various injuries occur at different times?
4. Are there patterns caused by a particular instrument (e.g., a belt buckle, a wire, a straight edge, coat hanger, etc.)?
5. Are injuries inconsistent with the explanation offered?
6. Are injuries inconsistent with the child's age?
7. Are the patterns of the injuries consistent with abuse (e.g., the shattered egg-shell pattern of skull fractures commonly found in children who have been thrown against a wall)?
8. Are the patterns of the burns consistent with forced immersion in a hot liquid (e.g., is there a distinct boundary line where the burn stops—a "stocking burn," for example, or a "doughnut" pattern caused by forcibly holding a child's buttocks down in a tub of hot liquid)?
9. Are the patterns consistent with a spattering by hot liquids?
10. Are the patterns of the burns consistent with the explanation offered?
11. Are there distinct patterns caused by a particular kind of implement (e.g., an electric iron, the grate of an electric heater, etc.) or instrument (e.g., circular cigarette burns, etc.)?

RESOURCE PAPER: BEHAVIORAL INDICATORS OF ABUSED CHILDREN

Children who are abused physically or emotionally display certain types of behavior. Many of these are common to all children at one time or another, but when they are present in sufficient number and strength to characterize a child's overall manner, they may indicate abuse. More than simple reactions to abuse itself, these behaviors reflect the child's response to the dynamics of the family and especially to disturbed parent-child interactions. They are mechanisms for survival in a world where children are either unable to fulfill certain basic needs at all, or can fulfill them only by denying, suppressing or exaggerating important parts of themselves. Frequently learned in infancy, these behaviors become a child's "mode of operation" used to cope with the world at large. The behaviors which characterize abused children fall into four categories:

1. **Overly complaint, passive, undemanding behaviors aimed at maintaining a low profile, avoiding any possible confrontation with a parent which could lead to abuse.** The child has adapted to the abusive situation by trying to avoid any behavior which the abusive parent notices at all.
2. **Extremely aggressive, demanding and rageful behaviors, sometimes hyperactive, caused by the child's repeated frustrations at getting basic needs met.** In effect, the child has also adapted, by seeking to provoke the needed attention with whatever behavior it takes to get that attention.
3. **Role-reversal behavior or extremely dependent behavior in response to parental emotional and even physical needs.** Abusive parents have been unable to satisfy certain of their own needs appropriately and so turn to their children for fulfillment. Their failure can produce two opposite sets of behavior in their children. If a *parent* needs parental attention, the child may be expected to assume this task, and become inappropriately adult and responsible. Other parents, with a need to keep their child dependent, will produce clinging, babyish behavior in the child long after a child in a healthy family would have become more self-reliant.
4. **Lags in development.** Children who are forced to siphon off energy normally channeled towards growth into protecting themselves from abusive parents may fall behind the norm for their age in toilet training, motor skills, socialization and language development. Developmental lags may also be the result of central nervous system *damage* caused by physical abuse, medical or nutritional neglect or inadequate stimulation. There may, of course, be organic or congenital causes for such lags in development.

Some abused children live in an uncertain environment where requirements for behavior are inconsistent and unclear. In some families, abuse is frequent and severe enough to be emotionally and physically harmful but insufficient to threaten physical survival. Frequently, discipline is meted out abitrarily in response to the parent's needs and feelings at the moment, rather than to punish a child for transgressing clear limits. Children may receive some love, affection and security from their parents but are also often frustrated in attempts to fulfill their needs. This inconsistency creates anger and frustration in the child which is frequently expressed indirectly with the parents, or by explosions with others outside the home.

Other abused children learned to do what the abusive parent wants or expects. At the other end of the spectrum from overly aggressive children, some adapt quickly to others' expectations. Unlike children who act out their frustration and rage, these children may have learned not to expect anything in the way of love or support. Their best efforts are directed at avoiding conflict which, in the context of the abusive family, can be triggered by expressing almost any kind of personal need, curiosity, anger or playfulness.

BEHAVIORS OF ABUSED CHILDREN IN SELECTED SETTINGS

Because the dynamics of abusive families vary, along with the individual personalities of the parents and children, an abused child's behavior is often sporadic and unpredictable, and a list of behavioral indicators is useful only as a general guide. Often, behavioral indicators draw attention because of drastic changes in patterns of behavior over time. The degree of an abused child's dependence on adults illustrates the point. Abused children have many needs, but because they have few expectations that these needs will be met, often they will not express them. In a safe environment, however, where the child perceives that it is acceptable to express needs, efforts to always "do the right thing" will soon disappear and be replaced by what can seem to be insatiable demands. The following settings and situations permit observations of some behaviors that could indicate past abuse.

Temporary Substitute Care

Depending on the severity of past abuse and the degree of openness permitted in a hospital or foster home, the behavior of abused children may vary. Some may whimper for their parents, while others will respond to the presence of adults who can give them more complete and loving care. If the rules are strict, the passive abused child is likely to be fiercely compliant; if the rules are more relaxed, the child may eventually begin to express the various needs which had been bottled up at home.

With Strangers

Abused children who display more aggressive behavior are likely to be indiscriminately friendly, attaching themselves to any stranger in a search to find someone to fulfill their needs. On the other hand, abused children who tend to be passive in their response, tend to be inhibited, withdrawn and wary of contact with strangers.

Eating

If eating is a specific area of conflict between a child and an abusive parent, any specific departures from the "normal" method of eating for a child that age can indicate abuse. An 18-month-old baby who is inappropriately neat in eating habits may be responding to an abusive situation in the family; the four-year-old who is totally compliant in eating behavior rather than very controlling of the environment may also be abused.

Playing

Many abused children simply do not know how to play and find no enjoyment in other children or toys. The way children behave in play offers insights about their inner state. A five-year-old who cleans up after every other child in kindergarten likely has some severe restraints on him at home, which could include abuse. Furthermore, many abused children, conditioned to be extraordinarily aware of their parents and the danger they present, will tend to be unaware of other children, engaging in little socialization. (Some are also insufficiently able to protect themselves from dangers in the environment, since their parents are the overwhelming subject of their preoccupation.) Abused children may pick frequent fights with playmates or disrupt other children, since that is the behavior their parents apply to them, and such displaced retaliation against their peers seems safe in contrast to the threat of further abuse if their anger were displayed around adults.

Going Home

Normal children will not want to stop play to go home; they may express some "crankiness" on the way home, but will, in general, be happy to see their parents. Abused children may not want to go home, but may almost instantaneously agree to go home without protest and may not show much enthusiasm on seeing their parents.

PARENTS' AND CHILDREN'S BEHAVIOR

Dr. Harold Martin of the University of Colorado Medical Center has pointed out, "It is not uncommon for abusive parents to reinforce 'bad' behavior that they verbally complain about. If part of the dynamics of the family is that the parents see the child as an extension of the bad part of themselves or that they need to have a scapegoat in the family, they will resist the child's acting 'normal' or 'good.' We've seen this in treatment and intervention programs where the parents sabotage attempts to help the child change his behavior quite unwittingly. Although a parent complains of behavior 'X,' one sees him reinforcing that behavior as if he needs to have the child acting badly for some reasons which, for the most part, are not conscious."

Ultimately, a list of specific behaviors to identify child abuse is useful only if the family dynamics which produce those behaviors are clearly understood. The behaviors, verbal and physical, indicate both the survival techniques the child has learned in order to exist in the family, and attempts—frequently inappropriate in kind or intensity—to get from others what the parents do not provide. The greater the abuse, the less the child will trust other people and the greater the child's difficulty in responding to love and care.

CHARACTERISTICS OF ABUSIVE FAMILIES

We all have the capacity to strike out in anger, fear, pain or frustration and this capability defines all of us as potential child abusers. Yet most of us are able to control these violent impulses. This profile concerns the broad categories of experience and dynamics that contribute to the abusive parent's inability to control these impulses. An increasingly comprehensive and authoritative body of literature defines seven general problem areas: 1) unfulfilled needs for nurturance and dependence, 2) fear of relationships, 3) lack of support systems, 4) marital problems, 5) life crises, 6) inability to care for or protect a child, and 7) lack of nurturing child-rearing practices. The following is not intended as a definitive profile of factors contributing to physical abuse. Rather, it is designed as an overview and reference guide to the special problems which can contribute to abusive behavior.

THE INFLUENCE OF PERSONAL FACTORS

Unfulfilled Needs for Nurturance and Dependence: Many abusive parents were significantly and consistently deprived of emotional support as children. They were unable to depend consistently on the adults in their lives for support, physical or emotional care, or love. The abusive parent's own needs to be parented were essentially unsatisfied. These unmet needs may carry over into adulthood and shape relations with family, friends and especially children. Fear, frustration and anger are associated with these unmet needs and abusive parents are more likely to act on impulses. The degree of fear, frustration and anger generally corresponds to the level of deprivation experienced in childhood.

Abusive parents often lack the skills and abilities necessary to provide emotionally for themselves. They have not learned to identify and obtain the emotional support they need from others nor have they learned how to cope with the anger, fear and frustration they feel, in relation to these unmet needs. As a result they experience a severe lack of self-esteem or sense of self-worth. Abusive parents feel unloved, unappreciated and unwanted. This negative self-image often leads to perceptions of themselves as insignificant, unattractive or stupid.

Low self-esteem can lead to low expectations. Abusive parents are likely to expect, even to invite rejection. A vicious cycle of negative self-image may lead to behavior which denies satisfying or fulfilling relationships with others. Some of this behavior is focused on avoiding most social interactions as a method of avoiding rejection and failure. Other, more aggressive or offensive behaviors may actually provoke rejection—abusive parents may actually make themselves difficult to like.

While they still desperately need the support and reinforcement denied during childhood, they are at a loss as to how to achieve it, and may, in fact, act in ways which serve to deny them the sense of belonging and worth they so strongly need.

In addition, many abusive parents were themselves physically or sexually abused as children. They tend to accept extreme forms of physical punishment as normal aspects of parent-child interactions.

Isolation: Abusive parents expect very little from others in the way of friendship or support. They avoid rejection and anger by breaking off close personal relationships. They avoid committing themselves to caring relationships with neighbors, friends, and even family. They are afraid to reach out to make contact. If both parents have a sense of personal isolation, the problem is compounded. The family will be cut off from all outside sources of support. This internal dependency exerts added pressures on the family unit which may further increase the likelihood of abuse.

Lack of Ability to Care for and Protect a Child: The abused child may fill one of many roles in the family and in a parent's life. She/he may represent an attempt on the parent's part to fulfill needs for love, acceptance and dependence. This situation constitutes a type of role-reversal in which the child becomes the nurturer of the parent, the life-giver. When the child is unable to fulfill the parent's emotional needs, the resulting frustration and disappointment can lead to abuse.

The child may also be perceived by the parents as an extension of self. The parents' lack of self-esteem and negative self-image may be projected onto the child as well. The child becomes a scapegoat and is made to pay for the parents' sense of inadequacy and failure.

The special child—one who is mentally, physically or developmentally handicapped and may have special needs or require extra parental attention—may provoke feelings of resentment in the parent. In these cases, parent-child bonds may be too weak to protect the child from parental frustration and anger. In addition, these children may react to abusive dynamics in the family by developing personality or behavior traits that are unattractive. These traits may actually heighten the likelihood of abuse and place these children in constant danger.

Lack of Nurturing Child-Rearing Practices: Abuse may also be contingent on the child-rearing practices used by the family. Child-rearing skills are acquired by observing family, social and cultural role models. Abuse may result from child-rearing practices which, while considered unacceptable by community standards, are seen as normal within the family unit.

Various cultures and sub-cultures have a variety of child-rearing patterns and methods of punishment which are considered appropriate for unacceptable behavior. These methods may be passed from generation to generation even after they become unacceptable by community standards. In some cases, these punishment practices can result in injuries or conditions that are considered abusive by the community even though the family may consider them to be normal child-rearing.

In addition, parents may have unrealistic expectations of a child's developmental abilities. They may be unfamiliar with what a child can be expected to do at a certain age. Punishment is inevitable when a child fails to meet inappropriate expectations. In other cases, performance or developmental standards may reflect parental attempts to control the child. The parent may be acting out a need for dominance by demanding high levels of performance from a child. When the child fails to perform at these inflated levels, the parent's frustration results in abuse.

It is important, in looking at this kind of overview and reference guide for the special problems which can contribute to abusive behavior, to recognize that no one abuser suffers from all of the problems noted, nor does any one abuser have all of the characteristics cited. Some characteristics are even contradictory. Abusers do, however, tend to have a number of problems and characteristics in common and represented here.

THE INFLUENCE OF ENVIRONMENTAL FACTORS

Lack of Support Systems: Frequently, abusive parents are emotionally unable to establish or utilize outside support systems even when the opportunity is available. They have not learned how to ask for and receive the kind of help they need to provide for themselves and their children. This inability intensifies the danger in times of crisis. With outside lifelines cut off, the abusive parent has nowhere to turn during periods of heightened stress. Often, it is during these periods that the potential abuser becomes the actual abuser.

Marital Problems: The lack of support systems often extends to marital relationships. Abusive parents frequently find themselves locked into a nonnurturing, noncommunicative marriage in which neither spouse is able to support or adequately meet the other's needs. Children are involved in the process of the parents' acting-out of anger and frustration. The child may be ignored or abandoned because he constitutes a painful reminder of marital dissatisfaction. A child who reminds one parent of the other may become the target of displaced anger. The parents may use the child as a seesaw, tugging and pulling at both ends for attention. Mutual abuse of a child may represent the only common ground established between parents. Regardless of the dynamics, the child becomes a conduit for indirect, often angry communications between two frustrated adults. If physical violence is part of parental interaction, this violence is likely to extend to the child as well. A pattern is established in which frustrations are dealt with physically and restraint of impulses to physically violent behavior is diminished by all family interactions.

Life Crises: External stress is frequently a contributing factor in abuse. Loss of employment or housing, lack of food or clothing, or indebtedness, any domestic crisis which precipitates fear or anxiety, can push the parent into abuse. Significant personal loss such as the death of a close relative or the relocation of a friend or neighbor can strip the parent of precious support mechanisms, heighten the sense of futility and create a feeling of inability to control one's own life. This loss of control can in turn lead to abuse and neglect.

On the other hand, external stress can be a way of life for some abusive families. Some families are crisis-ridden; it is a life-style posture. Everything is a crisis; the parents are unable to deal with daily pressures or control their environment. These parents actually seem to generate crises.

THE THOMAS CASE
with Discussion Questions

THE REPORT

On August 17, 1976, at 12:10 p.m., the Child Protective Service office in Port City was contacted by Lorraine Shotwell of 3742 55th Street, Apt. 5, concerning possible child beating. Miss Shotwell said she had seen a man in Apartment 2 beating his four-year-old daughter with a wide belt and that the child had numerous bruises resulting from the beating. Miss Shotwell also stated that she had seen the man in Apartment 2 pick his three-year-old son up by the hair and lift him roughly over a fence.

THE INVESTIGATION

Ms. Louise Allen was assigned to make the Child Protective Service's investigation on this report. She arrived at the home of Mr. and Mrs. Peter Thomas, in Apartment 2 of 3748 55th Street, at 4:15 p.m. the same day. Mr. Thomas was informed that Ms. Allen was there to investigate possible child abuse. Mr. Thomas was concerned and cooperative. Ms. Allen asked if she could examine and talk to Mari, his four-year-old daughter.

Ms. Allen found fresh bruises from the middle of Mari's shoulder blades to the middle of her buttocks. The bruises were elongated, as if caused by a belt. Mari also had a horse shoe shaped bruise on her stomach which appeared to Ms. Allen as though it could have been caused by the buckle of the belt flicking around her waist and hitting her on the stomach. Though clearly in pain, Mari did not cry while Ms. Allen examined her back. The Thomases' three-year-old son, Peter, Jr., was also examined and there was a scratch and redness on his right cheek. There were no other visible signs of possible abuse on the boy. Peter was quite frightened as Ms. Allen examined his torso and went immediately to his mother for comfort when she had completed her examination. When Mr. Thomas was questioned about the bruises, he said Mari had gone to the corner where she knew she was not allowed to go. Mr. Thomas said his father had strapped him until it hurt to sit for days and it had not left any scars on him. Mr. Thomas stated that it was his business how he disciplined his children and not his nosey neighbors'.

Mrs. Thomas stated that her husband was even-tempered normally and that Mari deserved the strapping that she got.

Discussion Questions:

1. What are the physical indicators of child abuse?
    - Mari
    - Peter, Jr.
2. What are the behavioral indicators of child abuse?
    - Mari
    - Peter, Jr.
3. What are parental characteristics that suggest a possible child abuse problem?
4. What other kinds of information would you like to know about the Thomases?
5. If Mari's bruises had first been discovered by you, either in your professional role or as a neighbor, would you have called Child Protective Services? Why? Why not?

THE BACKGROUND

Mari is Peter and Noreen Thomas' first child. Mrs. Thomas states that Mari's birth and development have been normal. The mother further indicates that Mari has always been a happy, well-behaved child. She further said that Mari is not now and never has been in preschool because she is not completely toilet-trained.

Mr. Thomas readily admits that he strapped his daughter. He believes he should have.

There is no prior history with the Port City Child Protective Services unit or the Police Department indicating abusive behavior on the part of the Thomases.

At the time of the Child Protective Service investigation in this report, the Thomases became somewhat hostile and apparently felt that they were being singled out by the agency.

Interviews with the parents disclosed several facts about the parents, including a belief that unacceptable behavior should result in "strict" corporal punishment, a lack of familiarity with appropriate child-rearing techniques and anxiety about chronic financial difficulties.

The Thomases' youngest child, Peter, is an epileptic. His condition is controlled with medication. Peter is also somewhat hyperkinetic. Mr. and Mrs. Thomas sometimes find it difficult to keep Peter under control.

PARENTS' HISTORY

Noreen Thomas was born in Ogdensburg, New York. She was raised in a small community north of Albany. Her parents divorced when she was an infant and she has had little contact with her father throughout her life. Mrs. Thomas is a high school graduate. She worked for an insurance company for four years.

Mr. Thomas was born in San Francisco, California. He is one of four brothers. While Mr. Thomas was growing up, his father pursued a career in both the Navy and the Coast Guard, necessitating the family's continual movement. His parents remained married until his father's death several years ago.

Mr. Thomas is a high school graduate. He is a career man in the Navy, enlisted for approximately ten years. He is an electrical specialist and his rank is E–6.

The Thomases have resided in Port City for eighteen months. They have a two-bedroom apartment in an apartment complex. The apartment is somewhat cluttered although adequate housekeeping standards are met. It appears that the Thomases have more possessions than their apartment can accommodate.

The Thomases are expecting a child in October. The baby was planned. Since the birth of their two children, Mr. and Mrs. Thomas have taken out insurance policies for the children's college educations. Mr. Thomas also stated that when he was in Vietnam, he earned a silver star. This award entitles his children to a free education at a military school and at certain nursing schools.

Discussion Questions:

1. What factors in Noreen's and Peter's individual histories are significant in determining whether they need help as parents?
2. What additional factors in the Thomases' present life circumstances are significant in determining whether they need help?
3. What kinds of help might be offered?
4. Should a child abuse petition (or case) be filed with juvenile court in order to have supervision over this family to attempt to insure the protection of the children or to remove the children temporarily for their own protection? Why? Why not?

PROGRAM TITLE: *"PHYSICAL INDICATORS OF ABUSE: Signs of Alert"*
SOUND FILMSTRIP
LENGTH: 13 minutes—100 frames

PHYSICAL ABUSE: "Signs of Alert"

(Music)

(Music)

(Music)

(Music)

(Music)

NARRATOR (Female): Bruises . . .

. . . burns . . .

. . . lacerations . . .

. . . fractures . . . children sustain so many accidental injuries in the course of normal activity . . .

NARRATOR (Female): . . . but some injuries are not accidental and are caused by parents and caretakers who physically abuse their children.

The abused child who goes unrecognized may suffer repeated and sometimes fatal injury.

If we are to *identify* children in need of protection we must be able to recognize the signs of child abuse.

We call these signs of alert, physical indicators.

Physical indicators, alone, don't always prove child abuse. But certain kinds of injuries strongly suggest the possibility of abuse.

For example, the location, size, shape or color of bruises should sometimes alert us.

Be aware of bruises or welts on the back side of the body.

1. Focus frame: BEGIN SOUND HERE
2. Curriculum Title: "We Can Help . . ."
3. Title: PRODUCED BY URSA
4. Unit Title: IDENTIFYING THE PHYSICALLY ABUSED CHILD—UNIT 3
5. WARNING: SOME VIEWERS MAY FIND THE FOLLOWING MATERIAL DISTURBING TO WATCH.
6. Child at bottom of slide examining bruised knee.
7. Young child playing with matches.
8. Barefoot child approaching jagged piece of glass in sand.
9. Child with cast on leg.

10. Medical Photo: Abused child.

11. Medical Photo: Abused child—cigarette burns on hands.
12. Medical Photo: Abused child—CU: black eyes.
13. Program Title: PHYSICAL INDICATORS OF ABUSE: SIGNS OF ALERT Supered over #12.
14. Split screen: Bruise/x-ray/burn/laceration

15. GRAPHIC: "SIGNS OF ALERT: BRUISES" Supered over #16.
16. Medical Photo: Bruises on back of child.

And bruises or welts in unusual patterns—reflecting the use of instruments—like these from an electrical cord . . .	**17. Medical Photo: Cord welts on back of child.**
NARRATOR (Female): . . . or these, from a hairbrush. Belts, buckles, wire hangers and other instruments can also leave telling evidence of abuse.	**18. Medical Photo: Child with facial bruise from hairbrush.**
These clustered bruises indicate *repeated* contact with an instrument.	**19. Medical Photo: Clustered bruises on buttocks.**
Bruises will show a reddish color when new and only a few hours old.	**20. Medical Photo: Red bruises (close-up of #19).**
They turn purple and blue in approximately a week . . .	**21. Bluish bruise on leg.**
. . . and greenish yellow to brown in two to four weeks.	**22. Medical Photo: Dark brown bruise around eye.**
If you see many bruises, of various colors in unusual patterns or places, you are probably seeing a child who suffers repeated abuse.	**23. Medical Photo: Back showing multiple dated bruises.**
Certain kinds of burns also indicate child abuse.	**24. GRAPHIC: "SIGNS OF ALERT: BURNS." Supered over #25.**
These children have been immersed in hot water or chemicals—sometimes as a means of toilet training.	**25. Medical Photo: Immersion burn—hand.**
Immersion burns usually cover large areas and show clear lines where the immersion starts and stops.	**26. Medical Photo: Immersion burn—buttocks.**
NARRATOR (Female): Spatter or liquid burns, like this one from hot grease, indicate where hot liquid was poured or spilled on a child.	**27. Medical Photo: Grease burn on chest.**
Contact burns often show patterns revealing the hot instrument which has contacted the skin, in this case an electric hot plate.	**28. Contact burn—hand.**
Open flame and cigarette burns are sometimes administered as punishment or discipline to discourage children from playing with fire.	**29. Medical Photo: Cigarette burns on finger.**
Although they may appear on any part of the body, they are often discovered in places hard to see—like between fingers or toes or on the soles of feet.	**30. Medical Photo: Cigarette burns on soles of feet.**
And rope burns may indicate where a child has been bound.	**31. Medical Photo: Rope burns on ankles.**
Burns like these should alert you to the strong *probability* of abuse.	**32. Split screen:** **#31—rope burns** **#25—hand burn** **#27—chest burn**
Observing certain kinds of *abrasions* and *lacerations* should also raise questions.	**33. GRAPHIC: "SIGNS OF ALERT: ABRASIONS/LACERATIONS" Supered over #34.**
NARRATOR (Female): In very young children abrasions and lacerations of the lip, eye or any portion of the face are highly suspect.	**34. Medical Photo: Lip laceration.**
In infants, tears in gum tissue can be the result of forced feeding.	**35. Medical Photo: Infant with gum lacerations.**
In slightly older children, premature loss of teeth might be the result of a kick or a punch.	**36. Medical Photo: Child with lacerated gums and missing teeth.**
This child received injury through sexual abuse.	**37. Medical Photo: Abrasion—penis.**

Injuries to the face and external genitalia—especially in very young children—are always suspect.	**38. Split screen: #37 penis/#35 infant gum tear.**
Bruises, burns, lacerations, abrasions . . . children are abused in so many ways. Injuries like the ones shown here should alert you a child may need protection.	**39. Split screen:** **-cigarette burns on ankles** **-cheek abrasions** **-lacerated lip** **-bruises on buttocks**
Some injuries are not so easily visible.	**40. Child holding arm which shows no obvious signs.**
The need for x ray may be called to our attention by unexplained pain, swelling or limitation of motion.	**41. Same child showing arm to adult who looks on attentively and concerned.**
NARRATOR (Female): X rays can reveal different types of injuries associated with different forms of abuse.	**42. X ray—fracture of elbow.**
For instance, twisting or pulling a child with great force can cause metaphyseal fractures, a kind of splintering or chip on the end of a bone.	**43. Arm of child being pulled/twisted.**
Where metaphyseal fractures are diagnosed and a parent, child or caretaker is unable to provide reasonable explanation of injury, there is good reason to suspect abuse.	**44. Medical Illustration: Metaphyseal fracture.**
Vigorous twisting or pulling can also cause spiral fractures (fractures that wrap or twist around the bone shaft) and . . .	**45. Medical Illustration: Metaphyseal fracture.**
Epiphyseal separations. The epiphysis is a growth center for the bone necessary to the development of bone length. Normally, the epiphysis joins the metaphysis.	**46. Medical Illustration: Normal relationship of epiphysis to metaphysis.**
If the epiphysis becomes separated from the metaphysis, malformation of the joint can result. When epiphyseal separations go untreated, children may experience continuous pain, limited motion and limited use of limbs.	**47. Medical Illustration: Epiphyseal separation.**
NARRATOR (Female): Pulling or twisting can cause more subtle injuries than fractures . . . like periosteal elevation. The periosteum is the outer covering of the bone. In a young child it is loosely attached.	**48. Medical Illustration: Normal bone structure showing periosteum (leg).**
If traumatized, the periosteum can be detached or lifted from the bone, causing hemorrhaging underneath. Medical treatment is then needed to control hemorrhaging and reduce pain.	**49. Medical Illustration: Showing periosteum detached and hemorrhage (leg).**
Sometimes children complain of pain but x rays taken immediately after trauma to a bone may appear normal.	**50. Medical Photo: Normal x ray of leg. Title: NORMAL.**
But follow-up x rays taken 10–14 days later can reveal new bone formation around the site of injury—seen here as the enlarged area of this bone shaft. This tells us the bone has indeed been traumatized because recalcification indicates a bone is repairing itself.	**51. Medical Photo: Split screen #50/x ray of same body region showing extensive recalcification around the bone shaft. Title: "HEALING"**
Again, where no reasonable explanations are given for bone injuries, the question of abuse must be raised.	**52. GRAPHIC: Medical report: "DIAGNOSIS: PERIOSTEAL ELEVATION; POSSIBLE ABUSE."**
Finally, hair pulling can cause hemorrhaging by pulling or lifting the scalp away from the skull.	**53. Medical Illustration: Child's head showing**

	scalp lifted from skull. Area of hemorrhage indicated.
NARRATOR (Female): This kind of injury may manifest itself as a bald spot or hemorrhage under the scalp.	**54. Medical Photo: Bald and swollen area on child's head.**
(Rattles)	**55. Blurred motion of child being shaken.**
(Rattles)	**56. Another view of #55.**
Violent shaking can cause a variety of serious injuries . . . especially in very young children.	**57. Another view of #55.**
Injuries like subdural hematomas—hemorrhages occurring between the brain and its covering. These may also be caused by hitting. When acute, subdural hematomas can cause brain damage . . .	**58. Medical Illustration: Subdural hematoma.**
. . . or death.	**59. Medical Photo: Infant with enlarged forehead/ bruised eyes.**
Retinal hemorrhages and retinal detachments are other indications of abuse by shaking. These injuries can cause blindness.	**60. Extreme CU: Open eye of child.**
(Music)	**61. Child with eyes closed.**
In many cases, grab marks on the arms or shoulders are the most obvious signs that a child has been severely shaken.	**62. Grab marks on child's arm.**
(Drums)	**63. Blurred motion of fist, to suggest blows.**
(Drums)	**64. Blurred motion of feet/legs as in above.**
NARRATOR (Female): Hard blows and kicking can cause serious injury to vital organs.	**65. Medical Photo: Lacerated thigh.**
Organs like the liver, spleen, duodenum, or intestines.	**66. Medical Illustration: Full body outline of mid-section with liver, spleen, duodenum, small intestine and pancreas detailed.**
Vital organs like the inferior vena cava—a large vein feeding all blood from the abdomen and lower extremities back to the heart.	**67. Medical Illustration: Whole body: vena cava feeding blood from abdomen and lower extremities back to the heart. Normal.**
Strong blows or kicks can rupture this and other important structures—causing bleeding into the abdominal cavity . . .	**68. Medical Illustration: Ruptured inferior vena cava.**
. . . and bleeding may in turn cause blood clots—called hematomas—that block the duodenum and small intestines . . .	**69. Medical Illustration: Hematomas blocking duodenum and small intestine.**
. . . or inflammation of the abdominal lining.	**70. Medical Illustration: Inflamed abdominal lining.**
NARRATOR (Female): Finally, blows can displace nasal cartilage or fracture jaws.	**71. Medical Photo: X ray—jaw fracture.**
Children suffer serious injuries when kicked or hit with great force.	**72. Medical Photo: Child with jaw fracture.**
(Music)	**73. Medical Photo: Child with missing front teeth.**
When something about any injury to a child causes you to suspect abuse . . .	**74. Medical Photo: Child with bruise near eye.**

. . . considering the child's developmental ability to inflict self-injury will help you distinguish whether the injury is accidental or not.

A child's ability to hurt himself increases with age . . .

. . . and developmental ability.

(Music)

For example, older children can involve themselves in activities of increasing risk . . .

. . . and resulting injuries may often have quite plausible explanations.

NARRATOR (Female): But serious bruising on an infant's face is hardly ever self-inflicted.

Where you find accounts of accidents inconsistent with a child's age and developmental ability . . .

. . . or evidence of reported injuries that are unexplained

. . . or implausible accounts of injuries, there is good reason to suspect abuse, and report your suspicion.

Any of these signs strongly indicate the need for inquiry into the possibility of abuse.

Usually, no single physical indicator proves child abuse, but certain ones tell us when to consider an injury is inflicted—and not accidental.

Physical indicators then become meaningful in the context of other information like medical histories . . .

. . . observations of parent-child interaction . . .

NARRATOR (Female): . . . and observation of behavior symptomatic of abused children.

Some signs are easily observed, and clearly tell us *action* is necessary to protect a child.

Some signs are difficult to interpret without comprehensive medical information. When in doubt—invite other informed opinions to help you decide what action is necessary.

In most cases, it *is* possible to clarify whether an injury has been sustained through abuse.

And your familiarity with signs of abuse is crucial if children at risk are to be recognized and protected.

Confronting signs of abuse may be difficult . . . but if we're right—your reasons for knowing are the same as ours . . .

. . . so that we can do everything possible . . . to keep children safe—and alive.

75. Medical Photo: Child with cut on forehead.

76. Normal infant.

77. Small boy on jungle gym.
78. Older girl on jungle gym.
79. Boy falling from skateboard.
80. Same child holding injured side of face.
81. Normal infant.

82. Medical Photo: Child with black eye.
83. GRAPHIC: Medical Record: "CAUSE OF INJURY—UNKNOWN??"
84. GRAPHIC: Medical Record: (Shows implausible account of injury).
85. GRAPHIC: "INJURIES INCONSISTENT WITH AGE." "UNEXPLAINED INJURIES." "IMPLAUSIBLE ACCOUNTS OF INJURIES."
86. Medical Photo: Immersion burn—hand (repeat #25).
87. Concerned adult examining child's arm.
88. Child caressing distraught mother.
89. GRAPHIC: See filmstrip "Physical Abuse: What Behavior Can Tell Us"
90. Medical Photo: CU: buttocks with welts/bruises.
91. Doctor examining x ray.

92. Split screen: Abused child/group of normal children.
93. Child with black eyes (repeat #12).
94. Child with burns on hands (repeat #11).

95. Multiethnic/multiage group of children looking to camera.

(Music)
(Music)

Thoughtful/varied expressions.
96. Production credit.
97. Production credit
98. Medical photo credit
99. PROFESSIONAL MODELS WERE USED FOR SOME OF THE PHOTOGRAPHS IN THIS FILMSTRIP.

100. NCCAN/HEW credit.

PROGRAM TITLE: "*PHYSICAL ABUSE: What Behavior Can Tell Us*"
SOUND FILMSTRIP
LENGTH: 14 minutes—113 frames

(Music)	**1. Focus frame: BEGIN SOUND HERE**
(Music)	**2. Curriculum Title: "We Can Help . . ."**
(Music)	**3. Title: PRODUCED BY URSA**
(Music)	**4. Unit Title: IDENTIFYING THE PHYSICALLY ABUSED CHILD—UNIT 3**
(Music)	**5. Interior, night. Looking down a dark hallway. In the doorway at the end, illuminated from behind, stands a man. We can't make out his facial features very well. He is in shadow. Grainy film.**
(Music)	**6. Child's bedroom. Illuminated by yellowish and shadowy incandescent light. On one side a boy (7–10 years old) is sitting on the floor, back in a corner. He is staring at the door. The man is coming in the door.**
(Music)	**7. CU: Boy. Wide-eyed. Expressive, shadowy lighting.**
(Low sobbing of child)	**8. Bedroom wall—we see shadows of the man and boy. The man is raising his hand.**
(Low sobbing of child)	**9. Exterior, night or late evening. House. One window is lit.**
(Classroom sound effects)	**10. MS: Classroom. Same boy at a desk. Other students in the background. He is writing. Looks glum.**
NARRATOR: Suppose you saw this child where you work.	**11. CU: Boy, from front—vacant stare.**
Would you know he was being abused?	**12. MS: A teacher is leaning down, talking to**

	the boy. He's not paying attention.
An abused child doesn't always have visible scars or bruises.	**13. CU: Boy. Head down on table—arms folded. We see his eyes, staring, pensive.**
Sometimes his behavior is the only clue.	**14. Wide shot: Classroom. We see 7 or 8 children in desks. One (the boy) has his head down, is sleeping. Other students are alert, looking at teacher who is talking to them. One student is raising his hand. Super title: PHYSICAL ABUSE. WHAT BEHAVIOR CAN TELL US**
NARRATOR: You might also see a child with an injury and be uncertain whether it was inflicted or not . . .	**15. CU: Examining room. Doctor is examining a child. We see doctor's face and child in profile.**
or whether it's anything to worry about.	**16. MS: We see doctor, child, and child's parents in the background. We don't see the injury.**
If the parents' or the child's behavior is unusual or suspicious, it could alert you.	**17. Child is standing at door of examining room, back to us, head bowed. Parent is angrily scolding him.**
(Day care center sound effects)	**18. Wide shot: Day care center. Children playing.**
VOICE (Female): Certain behavior can be very helpful in spotting possible child abuse.	**19. Day care. One or two children playing.**
We all show in our behavior how we're feeling about ourselves—the problems that confront us—the needs that are left unsatisfied.	**20. Day care. Day care worker talking with other adults. Child on teacher's lap.**
Children usually display these things more openly than adults—they're always expressing themselves in their behavior.	**21. MCU: Day care worker with child on lap.**
VOICE (Female): And if something's not right in their lives, they don't try to hide it. They tell us—if we know what to look for.	**22. Day care. Girl looking sad.**
NARRATOR: Whether you're a day care worker, teacher . . .	**23. CU: Day care worker from before.**
. . . medical professional, social worker, therapist, or other professional, you have regular opportunities to observe the behavior of children or their parents.	**24. Two-way: Doctor from frame #15 and day care worker from #23.**
Unusual behavior often indicates something is going on in the family that's worth paying attention to.	**25. Different photo of "unhappy" child in frame #14 exhibiting some troubling behavior.**
The problem may be physical abuse. Or it may be something else.	**26. Same photo as frame #21 treated with graphic technique so that the behavior is at the center of a whirlpool on other**

In any case, the child and the family may need our attention.

NARRATOR: Let's look at the kinds of behaviors that are typical when abuse is taking place.

First, the situation where the child is severely and consistently abused by a parent or caretaker.

This generally causes introverted, or extremely passive behavior in a child.

Children who are consistently abused learn that their needs and activities will often provoke maltreatment from the parent.

So they learn to hide almost any behavior which could call forth abuse.

And withdrawal and introverted behavior become important ways of protecting themselves.

NARRATOR: The severely abused child strongly fears the total withdrawal of his parents' love and affection.

So he attempts to meet the parents' demands by being as good and quiet and exhibiting as few needs as possible.

He may appear immobile, passive. He decides his only protection lies in not expressing feelings normal for his age—either of joy or sadness, anger or affection.

effect—other parts of the photo are partially obscured.

27. Same child with hands raised in fearful gesture. Continue graphic treatment of the photo so that only parts are intelligible. Style of graphics are coordinated with illustrations which follow.

28. Illustration: 4-or 5-year-old child, crouching, with fearful gesture similar to previous frame. Ambiguous background.

29. Illustration: Child crouching with hands covering head. Multiple image of parent raising hand to strike.

30. Illustration: Closer in on profile of child looking down.

31. Illustration: Dinner table—from behind child—spilled milk on table. Parent figure is standing up. There is an impressionistic treatment so that the parent is almost flowing angrily towards the child.

32. Illustration: Profile, child before spilled milk. Parent's hands loom threateningly above him.

33. Illustration: Another angle of child; multiple auras extending toward parent emerge from him.

34. Illustration: On one side the child is reaching out. The parents stand on the other side, stern, expressionless. Color "aura" from child is rebuffed by parents' hands.

35. Illustration: Living room. Child sitting on chair in stiff position—stupid smile on face, hands neatly folded.

36. Illustration: Close up. Head and shoulders of same setting. Face is extremely stiff, withdrawn.

From the inside he's trying to avoid being hurt. "If I can become invisible, if nobody notices me . . .	**37. Illustration: Parents are sitting, talking, at kitchen table. Child is at head of table—cloud shape above him.**
. . . maybe they won't hurt me."	**38. Illustration: Close up of child floating on the cloud. Sad, dreamy look.**
(Hospital sound effects)	**39. Photo: CU: 7-8-year-old child in hospital bed, head on pillow. Face in similar position as preceding illustration. Sad look.**
VOICE (Male, conversational): Many children in a hospital situation will be withdrawn, shy, and more dependent than normal.	**40. Nurse performing some procedure or talking with another child. Child looks normal (but not big smile).**
So, you have to interpret children's behavior while understanding the context or setting that you're observing in.	**41. Wide shot. Children's ward of hospital.**
The severely abused child in a hospital will be even *more* extremely withdrawn and passive than other children.	**42. Same child as frame #39. Close up. Sad look.**
He will cry very little, won't seek comfort or accept it. He may be wary of physical contact—on the alert for danger.	**43. Nurse bending down—soothing child's hair. Child stares straight ahead—look of fear. Nurse looks concerned.**
He will seem cut off from the world—experiencing life as if he were totally alone.	**44. The child has turned away from the nurse.**
(Classroom sound effects)	**45. 9- or 10-year-old boy is looking out of the window of a classroom. Moody look. (Same boy as in introductory sequence.)**
In other situations, like a school or day care center, the severely abused child will relate to the world in the same way he relates to his parents.	**46. MCU: From front—the boy's face (looking) occupies ⅓ of the frame. We see the classroom in the background but out of focus. A teacher is looking at the boy. She is just out of focus also.**
VOICE (Male, conversational): He'll be noncommunicative, passive, shy.	**47. Boy, sitting quietly amidst other active children. We only see parts of other children—arms, legs, blurred as if in motion.**
He won't trust other children or adults to respond to or be tolerant of his needs.	**48. Closer in on boy—different angle.**
So he won't express them. He's fearful and wants desperately to do what's right.	**49. Teacher talking to the boy. Boy is not responding.**
NARRATOR: The severely abused child, as we've seen, has withdrawn from both his abusive parents and	**50. Illustration: Child in withdrawn, passive**

from other people and the world.	**posture atop cloud. (Same child and style as first illustration sequence.)**
In contrast, the child who is less severely abused, or infrequently abused, exhibits a different behavior pattern.	**51. Illustration: Another child beating her fists on the ground.**
This child does get some love and attention from her parents. She feels some security. Her needs are sometimes met by parents . . .	**52. Illustration: Child being held by parent. The figures are set in left ⅓ of the frame.**
. . . and sometimes responded to with anger, annoyance, or abuse.	**53. Illustration: Keep figures from #52. And figures of child being abused by parent.**
NARRATOR: She is often frustrated.	**54. Add child being rejected by parent (final third of frame).**
But she has enough of a sense of personal self worth to demand the attention she's not getting, to protest the pain she receives.	**55. Illustration: Close-up child's head and shoulders. Holding up fists, demanding look on her face. Mouth open as if crying.**
She retaliates. She is angry, aggressive, hyperactive, full of rage.	**56. Illustration: Multiple image of child moving, kicking plant.**
She *is* very involved in a relationship with the parent—trying to get attention, perhaps even provoking more abuse.	**57. Illustration: Child tearing plant leaves; parents look on from background.**
She is engaged in a struggle.	**58. Illustration: Child in close struggle with parent who looms threateningly above her.**
(Day care center sound effects)	**59. Photo: Child in day care setting. Raising fists, shouting.**
VOICE (Female, conversational): What you see in the less severely abused child is frequent acting out of frustration, needs, anger .	**60. Day care worker with same child, calming him and separating him from another child.**
VOICE (Female, conversational): This is a child who is looking for something, for somebody.	**61. CU: Child in #58.**
He's aggressive, disruptive, he can't seem to calm down. Actually he's demanding to be seen and heard.	**62. Two children fighting over a rope swing.**
Many children may do this, but the less severely abused child will do it to the extreme.	**63. Closer in on one child in #62.**
This is a crucial concern in observing behavior—how does the child act over a period of time?	**64. Day care worker watching same two children.**
It's not the occasional instance of aggression or hyperactivity we're worried about. It's when a child consistently acts this way that we might suspect abuse.	**65. Day care worker with child.**
Another clue to infrequently abused children is the way they seek attention by attaching themselves indiscriminately to anybody who comes along, hoping someone will fulfill their needs.	**66. Child clinging to leg of an adult.**
NARRATOR: So far we've looked at two kinds of behavior patterns which may arise from physical abuse.	**67. Split screen illustration. The mildly**

Not every abused child will fall into these categories.	abused child (aggressive pose) and the severely abused child (passive pose).
Some may exhibit a mixutre of both types of behavior.	**68. Illustration: One child—passive on one side and aggressive on the other.**
NARRATOR: And, every child who shows some unusual behavior is not necessarily abused.	**69. Illustration: Child clinging to father's leg. The figures occupy the left ½ of the frame.**
It's important to look for chronic, persistent, and extreme behavior which is unusual when compared to a well cared for child of the same age.	**70. Illustration: Keep figures from #65. Add another example of same child clinging to mother's leg.**
(Day care center sound effects)	**71. Add another example to #70: Child clinging to teacher's leg.**
It's also very important when observing behavior to be sensitive to children with different cultural backgrounds.	**72. Third world child in day care setting.**
Reactions to strangers, child-rearing practices, ways of expressing feelings may differ.	**73. Man holding child from #71.**
Behavior which *seems* unusual could be quite normal in another cultural context.	**74. Same child crying and clinging to man.**
Look at the child in other situations. See if the other parts of his life are balanced and positive.	**75. Same child with other children. Smiling or happy.**
	76. 18-month-old child eating or being fed.
VOICE (Female, conversational): Certain activities are particularly useful to observe to pick up unusual behavior.	**77. Another shot—child eating, adult feeding the child.**
The way a child eats, for example, usually reflects his age level. Most children under two are messy and explorative.	**78. CU: Same child—eating messily.**
But a young child who seems terrified of making a mess may be reflecting strict parental control.	**79. Different 18-month-old child. Food is neatly in front of him/her.**
Often we can tell how children relate to members of their family by observing how they relate to other children while playing.	**80. Three 8- or 9-year-old children playing peacefully in a schoolyard.**
The way a child plays can provide important clues.	**81. Day care CU 5-year-old child—very serious look.**
A five-year-old who always cleans up after other children may be reflecting a severe constraint placed on him at home.	**82. Same child is picking up toys and putting them away. Other children playing.**
Children who pick fights or who are disruptive may be reflecting the way they're treated at home.	**83. Playground: One child is shouting at the others, perhaps fighting over a toy.**
What's important is trying to understand a child's behavior from her own perspective—how abuse has affected her and how her needs are not being met by the parents.	**84. CU: Moody look, girl.**

VOICE (Male, conversational): Abusive parents not only fail to meet the needs of their children. They *themselves* have many unfulfilled needs left over from their own childhoods.

You might see certain behaviors where the parents turned to the children to meet those needs.

The very young child, for example, who takes care of the parent—who comforts and soothes when the parent is angry or frustrated.

Such behavior, in its extreme, is unusual for a child of this age. It is often a symptom of an abusive parent-child relationship.

Another situation which may indicate problems occurs when the child is unnaturally dependent on the parent.

You may see a child who clings to a parent or stays close long after a normal child would have wandered away.

This is a parent who needs to be needed—who asks the child to be totally dependent. This behavior may indicate an abusive relationship.

VOICE (Male, conversational): You may also be able to spot problems or add to your understanding of a case by observing how the parents themselves act.

Of course, an abusive parent who is being interviewed is bound to be under stress, and will react differently than in a normal situation. This has to be taken into consideration.

But abusive parents do tend to be awkward and uncomfortable with their children.

They may appear tense and stiff—not properly supporting or holding a young child for example.

They may not cuddle or comfort her very well—they don't seem to take much pleasure in touching the child.

Abusive parents may also seem anxious and overwhelmed by their child's needs.

VOICE (Male, conversational): They frequently experience feelings of powerlessness in their own lives.

And so they may fail to respond to a child's pain or discomfort.

85. Home. Mother seated at kitchen table. She is somewhat distraught—rumpled looking.

86. Wider shot. Mother is talking to another woman (social worker) who is taking notes. Two- or three-year-old child is next to the mother.

87. MS: Child is caressing or hugging mother's arm and shoulder. Mother has head down.

88. CU: Same child serious as he hugs mother.

89. Office. Social worker is interviewing parents and 5- or 6-year-old child is close to mother.

90. MS: From side. Child clinging to mother. Emphasize child.

91. From front. Parents. Child clinging, looking up at mother.

92. Clinic. Mother and young (1-year-old) child, waiting for examination.

93. Doctor interviewing mother, taking a medical history. Mother has strained expression. Child in view.

94. Mother lifting child up to exam table. She is supporting child by armpits.

95. Mother holding child in seated position on exam table—but awkwardly—her face looks tense. Child cries.

96. Mother, seated, child in her lap. She pays no attention, is looking away.

97. Hospital. Children's ward. Mother and father by hospital bed. 7- or 8-year-old child in bathrobe is sitting on edge of bed. Child is looking down, with hand to face, crying.

98. CU: Parents. They look very stressed.

99. Wide shot: A nurse has come over and is

	comforting the child. Parents are looking away.
They give the sense of not knowing what to do. They don't acknowledge the child's feelings.	100. Closer in: Nurse is looking up at parents with questioning look. Father isn't paying attention. Mother is awkwardly touching the child's arm.
(Music)	101. CU: Nurse.
(Music)	102. MCU: Child crying. Face buried in hands. Profile.
NARRATOR: You've seen a variety of behaviors which *may* indicate abuse. Observations like these cannot be the sole basis for reporting, but these behavioral symptoms may be the clue a family and child need help.	103. Split screen: Sad parents (from #98)/sad child (from #22)/passive child in hospital (from #43)/passive child in classroom (from #11).
Behavioral information puts physical indicators in perspective. Consider all these factors before making a report.	104. Repeat #66. Hospital. Child clinging to leg of adult.
NARRATOR: Any child, or parent may display some of the behaviors we've seen—that by itself doesn't prove that abuse exists.	105. Two children seen previously tugging at tricycle.
But if you see a persistent pattern of unusual behavior . . .	106. Repeat #13. Sad boy at desk.
. . . if you suspect it reflects an unhappy home and an abusive relationship . . .	107. Repeat #17. Parent scolding child at clinic.
. . . if you sense a child is in trouble . . .	108. Repeat #59. Child raising fists, shouting.
. . . look further—you may be the one who helps.	109. Repeat #60. Day care worker comforting child.
(Music)	110. Credits.
(Music)	111. Credits.
(Music)	112. PROFESSIONAL MODELS WERE USED FOR SOME OF THE PHOTOGRAPHS IN THIS FILMSTRIP
(Music)	113. NCCAN/HEW credit.

Unit 3: IDENTIFYING CHILD NEGLECT

UNIT 3.

Time: 2 hours
30 minutes

IDENTIFYING CHILD NEGLECT

DESCRIPTION:

This unit provides an introduction to definitional and identification issues related to child neglect. It contains: (1) a group discussion and leader presentation on definitions; (2) a filmstrip and discussion on physical and behavioral indicators; and (3) small group analyses of cases involving child neglect.

GOALS:

1. To present legal, social, medical and psychological perspectives on child neglect in order to help participants develop their own operational definitions and to assist them in identifying suspected cases with a greater degree of confidence.
2. To provide participants with an opportunity to consider instances of child neglect in order to help them define the need for intervention on behalf of endangered children.

OBJECTIVES:

At the conclusion of this unit, participants will be able to:

1. List at least five physical indicators of child neglect.
2. List at least three behavioral indicators that may suggest child neglect.
3. Describe at least two interactions between parents and children that may indicate child neglect.
4. Define the term *child neglect* as it is used in their state's reporting law.
5. List two reasons suspected child neglect should be reported.

RATIONALE:

While concern about child maltreatment usually is voiced in terms of child *abuse and neglect,* frequently little attention is given to child neglect. Yet, the statistics verify that child neglect is more prevalent than physical child abuse (as much as five times greater, according to American Humane Association statistics). This unit should contain a tone of urgency and seriousness that matches that of the unit on physical abuse. Child neglect also leaves lasting physical and emotional scars; it, too, may be fatal. The intent of this unit is to underscore the seriousness of child neglect and to support participants' willingness to act on behalf of children who are not receiving necessary care and attention.

ADDITIONAL STAFF NEEDED:

None

SPACE REQUIREMENTS:

One room suitable for audiovisual presentation and large enough to accommodate the total group and break-out space for four small groups.

EQUIPMENT:

35 mm. filmstrip projector and cassette tape recorder
Screen
Extension cord and adapter plug, if necessary
Easel pad or chalkboard
Felt-tip markers or chalk and eraser
Masking tape
Index cards (2 for each participant)

AUDIOVISUAL MATERIALS:

Filmstrip: *Identifying Neglect: Before It's Too Late*

BEFORE YOU BEGIN:

Obtain State laws defining child neglect. Possible sources include:

- Local child protection agency,
- Local child abuse and neglect council,
- Legal counsel for participants' local agencies,
- State attorney general's office,
- Local bar association library, and
- Regional Child Abuse and Neglect Resource Center

ACTIVITY	TIME	MATERIALS
1. Exercise and Leader Presentation: Definitions of Child Neglect	30 minutes	Index cards Resource Paper: "Definitions of Child Neglect" "Profile of Neglect: A Survey of the State of Knowledge of Child Neglect"
2. Filmstrip and discussion	35 minutes	Filmstrip: "Identifying Neglect: Before It's Too Late" Resource Paper: "Indicators of Child Neglect"
BREAK	10 minutes	
3. Small Group Analysis: Cases of Child Neglect	45 minutes	Four Case Studies
4. Discussion and Summary	30 minutes	

Duplicate resource papers, unless participants have their own copies of **WE CAN HELP RESOURCE MATERIALS.** Preview the filmstrip, checking to be certain that it and the projector and tape recorder are in working order and plan discussion for Activity 2. Duplicate sufficient copies of the four Case Studies of Child Neglect for small group analysis in Activity 3.

PARTICIPANTS' MATERIALS:

Resource Paper: *"Definitions of Child Neglect"*
Resource Paper: *"Indicators of Child Neglect"*
Case Studies of Child Neglect

ACTIVITIES

ACTIVITY 1. Exercise and Leader Presentation: "Definitions of Child Neglect"

30 minutes

Introduce unit (2 minutes)

The leader introduces this unit by stating the unit's goals:

1. To present legal, social, medical and psychological perspectives on child neglect in order to help participants develop their own operational definitions and to assist them in identifying suspected cases with a greater degree of confidence.
2. To provide participants with an opportunity to consider instances of child neglect in order to help them define the need for intervention on behalf of endangered children.

Pass out 2 index cards to each participant and introduce exercise (3 minutes)

The first activity focuses on definitions of child neglect. The training staff passes out two index cards to each participant.

The leader tells participants that they have 3 minutes to write their own definitions of child neglect. Participants should write the same definition on both cards.

Collect 1 index card from each participant (2 minutes)

After 3 minutes, the training staff collects one of the cards from each participant, leaving the other for the participant's own reference.

Read 5 to 10 definitions (2 minutes)

Discuss definitions (10 minutes)

The leader selects 5 to 10 participant definitions at random and reads them aloud. Then the leader asks the group to comment on the *differences* and *similarities* of the definitions.

Leader presentation (10 minutes)

The leader then presents the following information on definitions of child neglect, which parallels the information contained in the resource paper, "Definitions of Child Neglect," on page 34 of **WE CAN HELP Resource Materials.**

1. Definitions more difficult; involves chronic withholding of care

1. Child Neglect is more difficult to define than physical child abuse, perhaps because it may not produce visible indicators and may occur over a longer period. It involves chronic inattention to the necessary physical and emotional needs of a child.

2. Community standards are a part of definition

2. Child neglect is determined, to a large degree, by community standards of acceptable (and unacceptable) levels of child care. Examples can be medical, educational or levels of parental supervision.

3. Variations in legal definitions

3. Legal definitions in State reporting laws and State juvenile court laws vary greatly; from broad, general definitions involving psychological, emotional and moral as well as physical harm to specific, narrow definitions focusing totally on physical harm resulting from intentional failure to provide adequate care.

4. State law definition

4. Our state reporting (or juvenile court) law defines child neglect as

Issues in legal definitions

(Note: Does the definition refer primarily to intentional or willful parental failure to provide care *or* to a child's condition resulting from dangerously inadequate care for whatever reasons? Does the definition refer to psychological, emotional or moral harm, as well as physical harm? Does the definition designate responsible persons as parents only or as other caretakers as well?)

5. Community and social responsibility for child neglect

5. Responsibility for child neglect becomes an even more complex issue, if one agrees that the society at large can be culpable for child neglect.
6. The issues related to definitions of child neglect include:
   a. Are physical and/or psychological manifestations required as part of the definition?
   b. Is parental/caretaker intent an element of the definition?
   c. Is responsibility placed on parent/caretaker and/or society/community in the definition?

Model Act Definition

7. The Draft Model Child Protection Act, developed by the National Center on Child Abuse and Neglect, defines child abuse and neglect as an act or *ommission* of *parent or other person responsible for a child's welfare* which results in *harm or threatened harm.* Harm or threatened harm, in the context of neglect, is further defined as:
   - Failure to supply the child with adequate food, clothing, shelter, education, health care (though financially able to do so and offered financial or other reasonable means to do so).
   - Abandonment of the child.
   - Failure to provide the child with adequate care, supervision or guardianship by specific acts or omissions of a similarly serious nature requiring intervention of the child protective service or a court.

Check own definitions against issues

In summary, the leader asks participants to look again at their definitions and check to see how they have addressed these definitional issues.

ACTIVITY 2. Filmstrip and Discussion

35 minutes

Introduce filmstrip (2 minutes)

The filmstrip, "Identifying Neglect: Before It's Too Late," focuses on physical and behavioral indicators of child neglect. Participants should view the filmstrip with two specific objectives in mind:

a.To gain information on indicators of child neglect, and
b.To strengthen their own working definitions of child neglect from the content of the filmstrip.

FILMSTRIP

Show filmstrip (13 minutes)

Discussion:

Discussion (20 minutes)

The discussion should focus at first on the points of fact concerning the filmstrip. The leader may ask:

Questions of fact (5 minutes)

1. What were the physical indicators depicted in the filmstrip?
2. What were the behavioral indicators depicted in the filmstrip?
3. How did the filmstrip handle the issues of neglect/poverty and neglect/cultural diversity?

Note the resource paper: "Indicators of Child Neglect, on page 37 of the **WE CAN HELP Resource Materials.**

Note resource paper

Then the leader asks the participants to share cases of child neglect encountered in their own professional experience, including ones in which they took no action. As a participant volunteers to tell of a case, ask that the case be described in this format:

Participants' experiences (15 minutes)

1. What were the indicators?
2. What made identification difficult?
3. Did you get any subsequent information?
4. What were your feelings?

The leader may take "wall notes" on easel paper or the chalk board, as participants describe their own experiences.

Other participants should be encouraged to ask the volunteer participants questions for clarification, but the leader should declare any judgments as off limits. There should be sufficient time to allow for three or four case descriptions.

BREAK

10 minutes

ACTIVITY 3. Small Group Analysis: Cases of Child Neglect.

45 minutes

The leader introduces this activity as an opportunity to consider cases of child neglect and to discuss them in a small group setting. Each small group will be asked to present an outline of its case to the entire group as a part of the summary discussion in Activity 4. Divide the group into four small groups and have each move to a separate corner of the room to:

Introduce exercise (5 minutes)
Divide into 4 small groups

1. Read one of the cases.
2. Discuss its case, using the questions provided.

Each small group should be supplied with easel paper, felt-tip markers, masking tape and a convenient wall or easel for making "group notes" as it discusses the questions for its assigned case.

Small group case analysis and discussion **(40 minutes)**

ACTIVITY 4. Group Discussion and Summary

30 minutes

Group reports (20 minutes)

The group reconvenes and "group notes" are placed on walls so that the entire group may see them.

A representative of each small group gives a sketch of the case history considered by the small group and then summarizes the group's answers to the discussion questions.

The leader may ask each group if there were any disagreements among members of the group and have them described to the whole group. The leader should encourage questions from the whole group.

Finally the leader should ask the group to consider how these neglect cases fit with the "ecology of child abuse and neglect" (see Unit 1). Does a consideration of individual capacities, personal attitudes and beliefs, specific life situations and the general community welfare help to understand these and other cases of child neglect?

Summary of unit (10 minutes)

To summarize this unit, the leader may use the unit objectives as a set of final questions for group discussion in order to emphasize the main points that have been covered.

1. What are some physical indicators of child neglect?
2. What are some behavioral indicators of child neglect?
3. What are interactions between parents and children that may indicate child neglect?
4. How is the term *child neglect* defined in our state's law?
5. What are reasons why professionals should consider reporting suspected cases of child neglect?

RESOURCE PAPER
DEFINITIONS OF CHILD NEGLECT

Difficulties in Defining Child Neglect

Developing a precise definition of neglect is not an easy task. In contrast to physical abuse, which usually has specific medical indicators such as bruises or broken bones and which occurs at a specific time, neglect may not produce visible signs, and occurs over a period of time. Neglect is usually a *chronic* failure to provide necessary physical and emotional support for a child. It is determined by a pattern of inattentive and/or dangerous child-rearing practices. But what does "chronic" mean? How long does it take to establish a pattern? What are dangerous child-rearing practices? The answers to these questions inevitably involve some degree of subjective judgment.

Community Standards

We can begin to answer these difficult questions by examining the child-rearing standards of the community. It can be said that neglect is seen by society as a deviant form of child-rearing which is unacceptable and harmful to a child, in contrast to those forms which are deemed growth-promoting and acceptable. Adequate and neglectful child-rearing are both socially defined terms. The dividing line between them may differ from one community to another and may change with time. Community A may condone certain child-rearing practices which Community B does not, or Community A may condemn today behaviors it deemed acceptable five years ago. While these flexible standards contribute to the difficulty of creating a single, universal definition of neglect, they indicate a basis from which we may approach the problem.

Legal Definitions

Lawmakers have also been faced with the difficulties of developing comprehensive yet precise definitions of neglect. Every State has adopted some type of legislation governing neglected children in order both to protect them and provide a legal basis for intervention and treatment when children are endangered. Almost all States now make provisions in State laws for reporting suspected cases of child neglect.

Such laws contain definitions of child neglect similar to the one contained in the Draft Model Child Protection Act, developed by the National Center on Child Abuse and Neglect. Child neglect is defined there as an omission by a parent or other person responsible for a child's welfare which results in harm or threatened harm. Harm or threatened harm is further defined in the following terms:

- Fails to supply the child with adequate food, clothing, shelter, education (as defined by State law), or health care, though financially able to do so or offered financial or other reasonable means to do so; for the purposes of this Act, "adequate health care" includes any medical or nonmedical remedial health care permitted or authorized under State law; a parent or other person responsible for a child's care legitimately practicing his religious beliefs who thereby does not provide specified medical treatment for a child shall not be considered neglectful for that reason alone; or

- Abandons the child, as defined by State law; or

- Fails to provide the child with adequate care, supervision or guardianship by specific acts or omissions of a similarly serious nature requiring intervention of the child protective service or court.

In many communities, neglect is also defined in the regulations of various agencies such as police, probation, or social welfare. Again, some of these definitions are very specific as to what constitutes neglect while others define the term broadly, encompassing a wide range of circumstances which are deemed neglectful with little emphasis on who is responsible for those circumstances or whether they come about intentionally.

In our State the law defines neglect as

follows: ______________________________

____

____

____

Conclusion

We may never arrive at a precise definition of child neglect that protects the child, allows for differences among child-rearing practices, and provides the professional with cut-and-dried guidelines for identification and treatment. Having said that neglect is a condition of inadequate care causing immediate or long-range damage to the child, we are left with the task of translating this concept into workable and equitable laws. The laws and definitions discussed in this unit have attempted to define neglect by asking:

- Must it be manifested in physical and/or psychological harm to the child?
- Must it represent an intentional act or acts by parents and/or caretakers against the child?
- May parents alone, other caretakers or the entire community be held responsible for causing neglect?

RESOURCE OUTLINE
INDICATORS OF CHILD NEGLECT

A. Abandonment

Children abandoned totally or for long periods of time.

B. Lack of supervision

1. Very young children left unattended.
2. Children left in the care of other children too young to protect them.
3. Children inadequately supervised for long periods of time or when engaged in dangerous activities.

C. Lack of adequate clothing and good hygiene

1. Children dressed inadequately for the weather or suffering from persisent illnesses like pneumonia or frostbite or sunburn that are associated with excessive exposure.
2. Severe diaper rash or other persistent skin disorders resulting from improper hygiene.
3. Children chronically dirty and unbathed.

D. Lack of medical or dental care

Children whose needs for medical or dental care or medication and health aids are unmet.

E. Lack of adequate education

Children who are chronically absent from school.

F. Lack of adequate nutrition

1. Children lacking sufficient quantity or quality of food.
2. Children consistently complaining of hunger or rummaging for food.
3. Children suffering severe developmental lags.

G. Lack of adequate shelter

1. Structurally unsafe housing or exposed wiring.
2. Inadequate heating.
3. Unsanitary housing conditions.

H. In identifying neglect, be sensitive to:

1. Issues of poverty vs. neglect.
2. Differing cultural expectations and values.
3. Differing child-rearing practices.

CASE HISTORY #1
AND DISCUSSION QUESTIONS
THE CARR FAMILY

THE PRESENTING PROBLEM

On November 25, 1974, Mrs. Thelma Carr brought her three daughters (Dolores, 7; Laura, 4; and Mindy, almost 2) to the police station. She told the officer on duty that neither she nor the children's father, Mr. Henry Carr, was capable of taking adequate care of their children, nor did they have any friends or relatives who were. That same day, the police assisted Mrs. Carr in placing the three children in the county Department of Social Services youth shelter. Shortly thereafter, Mr. Carr appeared with a babysitter he had just hired and asked to take the children home.

FAMILY HISTORY

Married in 1967, the Carrs have a history of separations, unemployment, and financial difficulties. When they separated in 1972 (before their youngest child was born), Mrs. Carr placed the two girls in the care of a babysitter during the hours she worked in an amusement park. One day Mr. Carr appeared at the babysitter's and took Laura away without his wife's knowledge. The uproar that ensued was resolved by placing the children in foster care, where they stayed for six months until the Carrs reconciled. The family later moved to their present address, the third city they have lived in since their marriage.

In February of 1974, when Mr. Carr lost his job as a taxi driver, the family applied for assistance from the Department of Public Welfare. During this period the children stayed with Mrs. Carr's parents in a nearby city. Before the assistance could be granted, however, Mr. Carr obtained another job, and the case was closed.

Two weeks before Mrs. Carr appeared with her children at the police station, she and her husband separated again; Mrs. Carr left the girls with her husband in the hope that he would find an adequate caretaker for them. Neighbors report that he did not make adequate provision for them, they were poorly fed and supervised, and were sometimes seen outside late at night, poorly clothed and in the rain. The neighbors were apparently convinced that the children were not developing normally (especially Laura and Mindy, the younger two), and a group of them told Mr. Carr that they would call the police unless he had his children checked by a doctor. This warning prompted Mr. Carr to take the girls to the hospital clinic, where the attending pediatrician noted that all three children were filthy. He also diagnosed Mindy, the two-year-old, as a failure-to-thrive child due to poor nutritional and hygienic care. He sent a referral form for Mindy to the probation department, which arrived after Mrs. Carr had already placed the children in the department's youth house.

The following information has been collected regarding family members:

Mr. Henry Carr. The eligibility worker on the Carr's assistance case noted that Mr. Carr is an apparently good worker and union member, who occasionally loses a job because of two- to three-day binges. He is also apparently able to get another job as a taxi driver fairly quickly. From other sources it was determined that he did not follow up on the hospital pediatrician's instructions given two weeks before the children were placed in the youth house.

Mrs. Thelma Carr. Herself an only adopted child, she seems to be the dominant member of the family, according to the eligibility worker, but leaves responsibility for child care to her husband when he is home. The Carr's landlord complained to the eligibility worker that while the two older girls seemed adequately cared for, Mindy was seldom changed or dressed properly. Both parents admit that their children had not received medical care for a period of two years prior to Mr. Carr's "enforced" visit to the hospital clinic.

Dolores Carr. Now seven years old, Dolores is developmentally normal. Her first grade teacher reports that she comes to school regularly, but is always very unkempt. Although her work habits are sloppy, she is one of the brightest children in the class. She has been largely responsible for the care of her two younger sisters.

Laura Carr. Laura is four. When she was born she had so much difficulty retaining food that she had to spend ten days in the newborn intensive care section of the hospital. During her first year she cried most of the time, and according to her parents did not walk until she was two and one-half years old. Mrs. Carr reports that she began to catch up in her development during the six months she spent in foster care in 1972. When she was returned to her parents she continued this growth, but not at such a rapid rate. Youth house officials saw her developmental difficulties primarily in her speech and motor coordination: she is enuretic (consistent bed-wetter), does not speak intelligibly, will not walk without assistance, and tends to drag her right leg. A psychologist who examined her found her likeable and cooperative, but fearful of new tasks and of guessing, and while she found her speech intelligible, she reported a definite need for speech therapy. She also stated that Laura's emotional attachment remains with her natural family, particularly with her mother.

Mindy Carr. Now almost two, Mindy is an extremely thin child with a large head. She weighed seven pounds at birth, would not cry and had to be given oxygen. The attending physician noted a distended stomach and felt a spinal tap was necessary. Mindy was kept in intensive care for 11 days before she was allowed to go home. Mrs. Carr states that Mindy did not receive follow-up medical care, but gained weight and ate well after coming home. At the youth house, Mindy is unable to sit up or to engage in play. A psychologist who tested her found that her responses are on a level of a 10- or 11-month-old child.

DISCUSSION QUESTIONS:

1. What are the indicators of neglect in this case?
2. How does this case fit (or not fit) your State's definition of child neglect?
3. What seems to be the Carr family's underlying problem?
4. Are there any contra-indicators in this case (factors which suggest an explanation other than neglect that would account for the conditions and behaviors of the family)?
5. What additional information, if any, do you need to decide what you would recommend be done to insure adequate care for the Carr children?

CASE HISTORY #2
AND DISCUSSION QUESTIONS:
THE MILLER FAMILY

THE PRESENTING PROBLEM

On October 17, the Rescue Squad in Glenn Canyon answered a call from Mrs. Denise Miller, who reported that her ten-year-old son, Robert, had been bitten by their dog and needed medical attention. Arriving at the Miller ranch, the paramedics noticed a strong smell of dog waste and "other unidentifiable odors"; they could see a number of Doberman Pinschers barking from three windows in the house. One window had no glass and the other two had torn screens. After knocking at the door for approximately one minute, they were admitted by Mrs. Miller, who directed them to her son lying on a sofa. The paramedics examined the boy and found large lacerations on his right arm and leg. They told Mrs. Miller that her son needed medical attention and advised that they would take her with her son to the nearest hospital. Mrs. Miller left the room to get dressed.

Robert reported that it was "his own fault" that he had been bitten, since he and his 12-year-old sister, Susannah, had been using sticks to get the dog into the kennel, even though they knew the dog was afraid of sticks. He said that this was the same dog that had bitten Susannah last year, bites which had healed rapidly after his mother cleaned them with peroxide. When he was bitten, he and his sister started screaming. His mother came out of the house and shot at the dog, who remained loose somewhere on the property. She then took Robert inside to the sofa and called for help.

After the paramedics put Robert in the ambulance, the dog appeared and charged them. They quickly entered the ambulance cab. When ten minutes had passed, they shouted into the house that if Mrs. Miller didn't come out, they would leave for the hospital without her. She then came out, and went with her son in the ambulance to Deer Park Hospital, where Robert was treated in the emergency room and then admitted to the hospital for five days' further treatment. Hospital staff called the Child Protection Agency when they learned of the circumstances from the rescue squad paramedics. After being released, he was taken to an emergency foster home, where he joined his sister, who had been sent there while the case was being investigated.

FAMILY HISTORY

Mrs. Miller was married in 1961 to Thomas Miller, a career Navy man who is frequently at sea for long periods of time. They were divorced in 1967, and the father has not had contact with his family for the past 18 months, although he sends Mrs. Miller an allotment check each month. At the time of their divorce, Mrs. Miller attempted suicide and her children were sent to an emergency shelter until she recovered sufficiently to take them home.

Mrs. Miller has had trouble before because of her dogs. In fact, her move to Glenn Canyon was an attempt to avoid further trouble. Twelve months ago a neighbor in the suburban community where Mrs. Miller had lived lodged a complaint against her. The neighbor stated that Mrs. Miller kept 12 Doberman Pinschers (inside the house, much of the time); that aside from the noise they created, they befouled the inside and outside of the house; and, further, that Susannah and Robert had been known to go begging for food among the neighbors.

The Child Protection worker who investigated the complaint found the house indeed in a deplorable state, but the children appeared to be well-fed and healthy. Mrs. Miller reported that the dogs were kept in separate rooms in the house to keep the male dogs from fighting and killing each other, and from a female dog in heat. The Child Protection worker observed Mrs. Miller to be in a state of considerable anxiety, apparently a reaction to her neighbors' hostility towards the number of dogs in her home. Mrs. Miller claimed that because her neighbors deliberately provoked the dogs, she had to spend a great deal of time controlling the dogs; and that she had to spend as much as three hours a day feeding the dogs, since they had to be fed in pairs in order to avoid bloodshed. In short, the Child

Protection worker found that most of the family's attention was directed toward caring for the dogs.

Although Mrs. Miller recognized that she had no time left over after caring for her dogs, she was unable to find alternatives. She refused to give up the dogs and, while she said she wanted to buy a kennel, find work and make the time to attend to everyday activities, she claimed she didn't have time to act on these desires. Ultimately, the case based on the neighbor's complaint was closed because the charge that the children begged for food could not be substantiated; their health and development was normal; and Mrs. Miller's housekeeping, while substandard, presented no apparent health hazard to the children.

Although she did purchase her present Glenn Canyon ranch as a more suitable place for keeping large numbers of dogs, 18 Dobermans still live inside the house. In addition, she still owns her suburban house, where she keeps several dogs. Nor has she yet obtained a kennel license, and has so far been granted two extensions to permit her to keep dogs.

Additional information on Mrs. Miller and her two children includes the following:

Mrs. Denise Miller. She has been unemployed since June of the previous year, when she was fired from a four-year job as a probation officer with the county probation department. Her only present income is $150 per month child support. She received AFDC for five months until she was given her lump-sum retirement benefits from the county. She lived on that money until it ran out and has survived since then on borrowed money from relatives. She displayed a high degree of resistance to outside interference at the time of the neighbor's complaint a year ago.

Robert Miller. He states that the dogs are "like part of the family." According to his fifth-grade teacher, he is doing satisfactory work, is very dependable, hardworking, and seems to enjoy his school and his classmates.

Susannah Miller. Susannah is in the sixth grade, where her teacher reports she is rather introverted, but a good solid student, hard worker, and a pleasure to have in class. The teacher did observe a tendency of Susannah's to cry frequently, and says that she usually comes to school in dirty, tattered clothes. The school nurse at their suburban school said that Susannah and Robert were often teased by the other children because they came to school smelling of dog urine and "other unidentifiable odors."

Susannah told the paramedics who took Robert to the hospital that, while she knew their home was dirty, it was hard to keep it clean with so many dogs around. She also said that her mother treats Robert and her "real good," and that they want to stay with their mother and the dogs.

Discussion Questions:

1. What are the indicators of neglect in this case?
2. How does this case fit (or not fit) your State law's definition of child neglect?
3. What seems to be the Miller family's underlying problem?
4. Are there any contra-indicators (factors which suggest an explanation other than neglect that would account for the conditions and behaviors of the family)?
5. What additional information, if any, do you need to decide what you would recommend be done to insure adequate care for the Miller children?

CASE HISTORY #3 AND DISCUSSION QUESTIONS: THE HELLER FAMILY

THE PRESENTING PROBLEM

On March 21, neighbors reported Mrs. Victoria Heller and her seven-year-old son, Terry, to the Child Protection Agency. The investigating officer found Mrs. Heller incoherent, apparently unable to take care of her own needs, and afraid to stay in her apartment. He learned that she was extremely depressed over her brother's recent death from an overdose of heroin, and his wife's subsequent suicide. Believing that both Mrs. Heller and her son were in danger, he took her to the county hospital and had Terry placed in an emergency foster home for the duration of his mother's recovery.

FAMILY HISTORY

The family had first come to the attention of the Child Protection Agency a year earlier, when Terry's teacher notified the agency that Terry had not come to school for two days. Ordinarily a two-day absence would not have given the teacher concern, but she had been worried about his erratic behavior over the past month. The investigating worker learned from neighbors that Mrs. Heller did not reside at the address the school had reported, but rather next door in a duplex belonging to her boyfriend, David. Upon admittance there by Mrs. Heller, the worker found Terry with bruises all over his body. These bruises, Terry reported, were the result of a beating with a belt given by his mother two days before. Left alone in David's duplex while David and his mother had gone to New York, he had built a fire on the kitchen floor, because he was lonely and wanted something to do. When his mother and David returned, the fire had burned out, but his mother had become very upset and had beaten him. Terry told the officer that his mother and her boyfriend often left him alone when they went out of town.

In subsequent investigations, the Child Protection Agency worker determined that this beating was an isolated incident, that Mrs. Heller appeared very remorseful, and was willing to cooperate in any way with the investigation. She had apparently not realized the serious consequences of leaving a seven-year-old boy unattended, and agreed to arrange for one of her brothers to take care of Terry whenever she went out.

In December (eight months after the beating incident and four months before she was found incoherent in her apartment), Mrs. Heller had attempted suicide by slashing her wrists, and was hospitalized for three days. Terry stayed with his uncle during this period, and Mrs. Heller began therapy with a psychiatrist at the county hospital. The doctor prescribed medication and attempted to get her into group therapy, which she refused. One month later, Mrs. Heller was beaten up by her boyfriend, David. Apparently a common occurrence, this time it caused Mrs. Heller to move out of his duplex and into her present apartment.

The investigation has produced the following information about Mrs. Heller and her son Terry:

Mrs. Heller. One of 11 children, Mrs. Heller comes from a very low-income and dysfunctional family. Her parents were divorced after her father was convicted of having an incestuous relationship with one of her sisters. At a later time she and her brothers and sisters were removed from their mother's home and spent many years in foster homes.

Mrs. Heller married at 16, but was abandoned by her husband after a few months and re-referred to the probation department as incorrigible. She remained a ward of the court in foster homes until she was 18. She soon became pregnant with Terry, considered giving him up for adoption, but ultimately decided against it, since she was planning to divorce her first husband and marry again. Neither the divorce nor the marriage ever took place, but she kept the baby since she "really and truly" loved his father. She gave birth again in 1967 and 1968, but relinquished both babies at birth.

Between 1968 and 1970 she and Terry went back to live with her previous foster parents. In response to her request for training, the welfare department enrolled her in two different programs. She was dropped from the first because of poor attendance, and quit the second when she became emotionally unstable and made her first attempt at suicide. During this time Terry received adequate care from Mrs. Heller's foster parents.

In 1972 she terminated a fourth pregnancy by abortion.

Terry Heller. Mrs. Heller reports a normal pregnancy with Terry and a normal delivery. He has been a healthy child, and his development is normal. At school, however, he does not do well. He reportedly is slow in English and spelling, and average or below average in his other subjects. However, he is well liked by his teachers and by his school counselor, who has visited him regularly. According to the investigator's report, Terry is confused and unhappy as a result of his mother's emotional breakdown, and this state has adversely affected his school performance.

According to the department's consulting psychologist who examined him, there is a "strong, healthy, loving attachment" between Terry and his mother, and it would be emotionally detrimental to separate them.

Discussion Questions:

1. What are the indicators of neglect in this case?
2. How does this case fit (or not fit) your State laws definition of child neglect?
3. What seems to be the Heller family's underlying problem?
4. Are there any contra-indicators in this case (factors which suggest an explanation other than neglect that would account for the conditions and behaviors of the family)?
5. What additional information, if any, do you need to decide what you would recommend be done to insure adequate care for Terry?

CASE HISTORY #4 AND DISCUSSION QUESTIONS: THE MARKHAM FAMILY

THE PRESENTING PROBLEM

On March 5, Maureen Markham came to the probation department in Santa Barbara, California, requesting assistance in connection with her 14-year-old sister, Michelle, and her 12-year-old brother, Craig. Maureen is 20 years old, and a pre-med student at the University of California at Santa Barbara, where she lives in a two-bedroom apartment with Michelle. Craig attends a private school in southern California. Their mother lives in a half-way house owned by a community mental health organization in Washington. Maureen is concerned that when her mother is soon released from the half-way house, she will want Michelle and Craig to live with her in Elton Falls. Maureen states that her mother is a schizophrenic and incapable of caring for Michelle.

FAMILY HISTORY

The Markhams were married in 1948. Mr. Markham was a biologist who died of a heart attack ten years ago. The family now consists of Mrs. Markham and five children, of whom Maureen is the next-to-oldest. The family is of the Quaker faith, and has been active in church affairs for many years. Mr. and Mrs. Markham were involved in progressive education, liberal movements and intellectual pursuits. Maureen states that while her father was alive he took the children camping and the family did many things together. Since his death, however, Mrs. Markham has suffered bouts of depression and hospitalization during which she has failed to provide effective supervision for the children. The family is not without means. The family home in Elton Falls is rented, and all matters pertaining to it are handled by a trust. A conservator has been appointed for the mother's estate. Each child now receives $106 per month in social security benefits; in the past they also received some veterans' benefits, which Mrs. Markham's conservator is now trying to reinstigate. All other funds from the estate are being used to defray the costs of Mrs. Markham's stay at the half-way house. Over the last ten years, well-to-do relatives have helped the family out.

Mrs. Markham. Born in the Philippines of Swiss parents, Mrs. Markham suffered extreme physical deprivation as a teenager in a Japanese internment camp and as a result has always had emotional and physical problems. Frequent prescriptions of Seconal and Dexadrine resulted in a high drug dependency. She has received psychiatric therapy since before the death of her husband, and has been hospitalized several times for emotional problems. She has been diagnosed as schizophrenic, schizo-affective type. According to her daughters, she is a very intelligent woman, but after the death of her husband retired to her bed and allowed her children to take care of her. She continues to reside at the half-way house until she can find employment. Although she has been trained as a nurse's aide, she prefers work as a companion. Mrs. Markham does not feel that her behavior has been detrimental to her children, and wants Michelle and Craig, her two youngest, to live with her when she is released. She expects to find employment shortly, and to take an apartment for herself and her children then.

Frank Markham. At 22, Frank is the eldest of the five children. He resides in Elton Falls where he works as a commercial fisherman; at the moment he is at sea off the coast of South America. Frank helps the family financially when he can. He pays for Craig's tuition at a Quaker boarding school, and has provided Maureen with a car.

Marni Markham Craig. Marni, 18, resides in San Francisco with her husband and infant daughter. She has little active involvement with the family at the moment, although both Craig and Michelle have visited her during school holidays. Marni was arrested for possession of marijuana in 1969, but the case was dismissed.

Maureen Markham. When Michelle came to live with her last year, Maureen rented a two-bedroom married student apartment on campus. When Craig visits he takes one bedroom and the two sisters share the other. Until recently Maureen had a part-time job but she gave it up to spend more time with Michelle. According to the investigating social worker, Maureen provides a stable, wholesome environment for her brother and sister. She discusses things openly with them and seems able to provide normal care and guidance. She informed the probation officer that in 1969 she gave birth to a baby which she relinquished for adoption. She also admitted that in the past she has used marijuana and other drugs, although she denies that she is now a user.

Michelle Markham. The probation officer describes Michelle, 14, as a vivacious, attractive, and articulate girl. In July of 1971 she asked to move out of her mother's house and live in a foster home because of her mother's emotional instability and abuse of drugs. She lived in a foster home until the end of the year, when she went to Santa Barbara to live with Maureen. Maureen stated that there were some problems when Michelle first came to her because she hadn't been used to much supervision. She also said Michelle had trouble establishing relationships with adults, and with accepting them as authority figures—and indeed was unable to form a positive relationship with her foster mother. Maureen has obtained counseling for Michelle (paid for by her older brother Frank) and Michelle is now behaving responsibly. Her junior high school teachers report no attendance problems, and say she appears to be of above average intelligence. Michelle has stated that she does not wish to live with her mother when she is released from the half-way house.

Craig Markham. The headmaster of Craig's private school is an old friend of the Markham family. He reports that Craig, 12, has made an excellent adjustment to the school since his enrollment last year at the time of his mother's most recent hospitalization. According to Maureen, her mother had been very dependent upon Craig, who was a very immature child and had very few friends his own age. Craig does not want to live with his mother when she is released from the half-way house. He would prefer to continue at his school—visiting Maureen and, occasionally, Marni on school holidays.

Discussion Questions:

1. What are the indicators of neglect in this case?
2. How does this case fit (or not fit) your State laws definition of child neglect?
3. What seems to be the Markham family's underlying problem?
4. Are there any contra-indicators (factors which suggest an explanation other than neglect that would account for the conditions and behaviors of the family)?
5. What additional information, if any, do you need to decide what you would recommend be done to insure adequate care for Michelle and Craig?

PROGRAM TITLE: IDENTIFYING NEGLECT: "Before It's Too Late"
SOUND FILMSTRIP
12 minutes—100 frames

	1. Focus frame: START SOUND HERE
(Music)	**2. Curriculum Title: "We Can Help . . ."**
(Music)	**3. Title: PRODUCED BY URSA**
(Music)	**4. Unit Title: IDENTIFYING NEGLECT—UNIT 4**
MALE TEACHER: He was one of my students. Sleeping under parked cars for shelter.	**5. CU: News headline: "Child Killed Sleeping Under Parked Cars"**
I should have suspected something—clothes dirty and torn half the time. If I had . . .	**6. Male teacher reading newspaper.**
. . . maybe I could have done something—before it was too late.	**7. CU: Concerned teacher.**
NARRATOR: Too many children suffer tragedies of neglect.	**8. News headline: "Courts Hear 150,000 Neglect Proceedings Each Year"**
Its consequences can be as damaging to the physical, mental and emotional health of children as physical abuse. Child neglect is a serious problem . . .	**9. Pamphlet cover: "Profile of Neglect"—insert quote re: AHA neglect statistics.**
NARRATOR: . . . and people who deal with children have the opportunity to do something about it . . .	**10. Profile: Teacher looking out window at children in schoolyard.**
. . . when they can identify neglect—before it's too late.	**11. Silhouette child looking out window. SUPER TITLE—IDENTIFYING NEGLECT: BEFORE IT'S TOO LATE**
A child is neglected when basic needs for health and survival are not met . . .	**12. Small child inside car watching father leave car.**
. . . and when parents or caretakers have knowledge, money and assistance to provide adequate care . . .	**13. Father purchasing ticket at movie theatre window.**
. . . but don't. When you observe things in a child's behavior . . .	**14. Father eating popcorn, watching movie.**
. . . appearance or environment that suggests basic needs are not being met—ask: Is the child's health seriously threatened?	**15. Child in automobile reaching for keys and brake.**

Have parents or caretakers been offered help to meet the child's needs but refused it? If the answers are "Yes," you may be seeing child neglect, and the child may need protection.	**16. GRAPHIC: IS THE CHILD'S HEALTH SERIOUSLY THREATENED? HAS FAMILY REFUSED HELP?**
NARRATOR: Here are some of the signs that indicate neglect—signs that should concern you.	**17. GRAPHIC: Multisigns (e.g. ABANDONMENT, UNSAFE SHELTER, NUTRITIONAL NEGLECT, etc.).**
Obviously, abandonment is the most extreme form of neglect . . .	**18. GRAPHIC: Single sign—ABANDONMENT/LACK OF SUPERVISION**
. . . and many children *are* totally abandoned.	**19. Doll on staircase; adult feet existing from frame.**
Children who are left unattended or inadequately supervised for long periods of time can also be neglected.	**20. Silhouette of 2 children looking out window.**
For instance, children under two, left unsupervised while awake . . .	**21. Small arm turning on bathtub faucet.**
. . . can be at great risk . . .	**22. Doll floating in tub.**
. . . as can children left in the care of others too young to protect them.	**23. Portrait—9-year-old girl holding infant, 3-year-old by her side.**
Be aware when you see or hear of children locked out of the house for long periods of time—sometimes as punishment.	**24. Child sleeping in phone booth at night.**
NARRATOR: Be aware of children whose parents never seem to know their whereabouts . . .	**25. CU: Boy sleeping in phone booth, another angle.**
. . . whose parents fail to show concern when they stray or don't come home.	**26. Small child leaning against traffic light pole amidst heavy traffic.**
Any of these signs can mean a child receives inadequate supervision and is at risk.	**27. CU: Red light traffic signal reads "DON'T WALK."**
(Screeching car wheels.)	**28. CU: Car tire wheels—blurr motion.**
All children share the need for adequate clothing and good hygiene.	**29. GRAPHIC: INADEQUATE CLOTHING/POOR HYGIENE**
You may see children dressed inadequately for the weather who suffer persistent colds, pneumonia . . .	**30. Child wet from rain, blowing nose.**
. . . frostbite or sunburn from overexposure.	**31. CU: Medical photo: frostbite on foot.**
And you may see children with severe diaper rash or other persistent skin disorders indicating needs for clean clothing and proper skin care are not being met.	**32. CU: Medical photo: extreme diaper rash.**

NARRATOR: And if you see a child who is often dirty and unbathed, at least consider that it may reflect general lack of care.	**33. Dirty child in school setting.**
Children suffer medical or dental neglect when the need for treatment, medication or health aids goes unmet. The signs can be . . .	**34. GRAPHIC: MEDICAL/DENTAL NEGLECT**
. . . children whose teeth are rotting away—never receiving dental care; . . .	**35. CU: Medical photo: child with teeth showing extreme decay.**
. . . children with sores or injuries that don't show normal progress in healing; . . .	**36. Concerned adult examining child's arm.**
. . . children in need of prosthetics like eyeglasses, hearing aids or corrective shoes who—	**37. Child squinting at school blackboard.**
after the need is reported to parents don't receive these aids; . . .	**38. CU: Same child squinting—direct to camera.**
. . . and children who are often absent from class or other activities because medical problems go untreated.	**39. Empty classroom seat.**
Some children are victims of nutritional neglect—lacking sufficient quantity or quality in their diets over long periods of time.	**40. GRAPHIC: NUTRITIONAL NEGLECT**
NARRATOR: Where an infant's physical growth is so severely lagging that height and weight fall below the third percentile for that age group, the failure-to-thrive syndrome may be suspected.	**41. Medical photo: Failure to thrive infant (full body).**
An infant may fail to thrive because parents don't give enough food or because severe distrubances in the parent-child relationship prevent the infant from absorbing food.	**42. Medical photo: CU: Same as above, crying.**
If the child gains weight while under hospital care—an ounce a day is significant—it is assumed the infant fails to thrive in the home because of parental deprivation.	**43. Split screen: Left #41/right—CU: Same child after weight gain. (SUPER: "BEFORE"/"AFTER"**
You may see older children with more obvious signs of malnutrition.	**44. Child with marasmus.**
You may see a child who consistently complains of hunger . . .	**45. Child rummaging through garbage can.**
. . . begs or collects leftovers . . .	**46. Same child eating scraps from garbage.**
. . . or, who is often accused of stealing other children's lunches.	**47. Accusing finger points toward child eating apple.**
NARRATOR: Any of these signs can mean a child suffers nutritional neglect.	**48. CU: Same child—apple in hand.**
A child's health can be seriously endangered by hazardous conditions in the home.	**49. GRAPHIC: SHELTER NEGLECT**
Structurally unsound housing . . . exposed wiring . . .	**50. Holes in ceiling.**
. . . inadequate heating . . .	**51. Broken window.**
. . . and unsanitary practices can all be serious health hazards. When left uncorrected for long periods of time . . .	**52. Interior—house with extremely filthy conditions. SUPER:**

	POLICE PHOTO FILE
. . . inadequate provisions for safe shelter strongly indicate neglect.	**53. Mice on windowsill.**
Whether such conditions are caused by neglecting parents, caretakers, or landlords . . .	**54. News headline: "Rats Bite Sleeping Child."**
. . . we must be concerned when home environments threaten children's health . . .	**55. News headline: "Lead Based Paint Poisons 2-Year-Old.**
. . . or life. (Pause) Neglect—*the* most prevalent form of child maltreatment today . . .	**56. News article: "3 Children Die In Fire—Defective Wiring Blamed"**
NARRATOR: . . . a serious problem, yet not always easy to identify.	**57. Silhouette: Girl at window.**
Some people never suspect neglect because they assume what they're seeing is poverty.	**58. A teacher in rainclothes.**
TEACHER #2 (Female): Poor Maria . . . So wet and cold. She's never dressed adequately for the weather.	**59. Teacher in background looking at Maria, cold and wet.**
She's had a cold all winter.	**60. CU: Teacher looking concerned at Maria.**
TEACHER #3 (Female): I guess her parents can't afford to buy proper rainclothes.	**61. Two teachers talking in foreground, Maria in background.**
NARRATOR: Some signs of poverty do look like signs of neglect.	**62. Reverse angle—Maria descending staircase—teachers looking on in background.**
Some parents need financial assistance to provide adequate clothing for their children.	**63. CU: Bare feet.**
Some parents are so overwhelmed by family crisis, divorce, death and other kinds of stress they become apathetic toward themselves . . .	**64. Social worker talking with distressed mother. Child in view.**
NARRATOR: . . . and toward the needs of their children.	**65. Closer in: Same mother—unresponsive to child carressing her.**
And some parents have the money or assistance to provide proper care—but fail to do so for other reasons.	**66. Silhouette—man with alcohol at table.**
Poor or neglected, when you see a child missing essentials for good health—take an interest. Maybe you can do something to get those needs met.	**67. CU: Maria, wet and cold.**
And don't assume you won't find neglect among those well-to-do. Neglect cuts across all social and economic lines.	**68. Exterior—Wealthy homes.**
Although most reported cases come through agencies most in contact with the poor . . . the fact is . . .	**69. Exterior—Welfare Agency.**
. . . neglect among the well to do often goes unreported.	**70. CU: Partially opened iron gate.**

MOTHER #1: I don't have time to watch him every minute. Don't worry . . .	**71. Interior—glamorous mother talking on phone. Upper middle class surroundings.**
. . . he's a big boy now. He can take care of himself.	**72. Small child with sailboat approaching private swimming pool.**
MOTHER #1: See you at 6:00?	**73. CU: Capsized sailboat.**
MOTHER #2: There must be something in the refrigerator you kids can eat.	**74. CU: Another mother, talking.**
Take care of yourselves, now. I'll be back tomorrow.	**75. Despondent children looking up toward mother.**
NARRATOR: Neglect may be less obvious among middle and upper class families . . . but just as real.	**76. Same children looking in empty refrigerator.**
Sometimes differences in child rearing practices, cultural values or lifestyles lead people to see neglect where it doesn't exist.	**77. CU: Multicultural portrait—children.**
Because one child assumes greater family responsibilities at an earlier age than others . . .	**78. Young black child at laundromat—folding clothes.**
. . . doesn't mean she's neglected.	**79. Closer in—same child.**
Because some people eat differently than others—like vegetarian foods . . .	**80. CU: Vegetarian array of foods.**
. . . doesn't mean their children aren't well nourished and cared for.	**81. Father and son eating at table with vegetarian foods.**
NARRATOR: People live in many different ways.	**82. Wide on pedestrian traffic. Chinese mother/child in view.**
And being sensitive to different ways people live will help you distinguish what is really different from what is really neglect.	**83. CU:Chinese mother/child.**
Is the child's health seriously threatened? Have parents or caretakers been offered help to meet the child's needs but refused it? These are the important questions to answer when there is any confusion.	**84. Split screen: Chinese mother/child, Black girl, Maria—wet and cold, Combined with print: HEALTH AT RISK? HELP REFUSED?**
All Children share basic needs for health and survival.	**85. Infant.**
Until they can provide for themselves, they must depend on the care of others.	**86. Infant being fed milk from bottle.**
But when a child's basic needs go unmet—because parents or caretakers ignore those needs, children suffer neglect.	**87. Repeat medical photo: Failure to thrive infant.**
It may be easier responding to children who express emotional, mental . . .	**88. Happy healthy child swinging on jungle gym.**
. . . and physical well-being. It may be *much* easier . . .	**89. Another, happy healthy child swinging.**

NARRATOR: . . . than confronting signs of serious need.	**90. Repeat medical photo: Diaper rash.**
But will you recognize the child who is at risk for lack of adequate care?	**91. Repeat medical photo: Rotting teeth.**
Will you respond to the neglected child—before it's too late?	**92. Repeat photo of boy biting apple.**
(Song)	
A child is like a light you see.	**(Add-on split screen.)**
A light is like a hope.	**93. Add to #92: 2 children looking in empty icebox.**
Just like the hope in you and me.	**94. Add to #93: CU: Girl from empty icebox scene.**
What will you give	**95. Add to #94: Boy in car.**
To keep those lights aglow?	**96. Add to #95: Maria in red dress.**
(Music)	**97. Production credit.**
(Music)	**98. Production credit.**
(Music)	**99. GRAPHIC: PROFESSIONAL MODELS WERE USED FOR SOME OF THE PHOTOGRAPHS IN THIS FILMSTRIP.**
(Music)	**100. NCCAN/HEW credit.**

Unit 4: EMOTIONAL MALTREATMENT OF CHILDREN

UNIT 4.

Time: 2 hours

IDENTIFYING EMOTIONAL MALTREATMENT OF CHILDREN

DESCRIPTION OF UNIT:

This unit examines emotional maltreatment of children, with special focus on definitional issues, identification and child protective intervention. It includes: (1) a film/case study portraying the effects of parental deprivation and its treatment; (2) a presentation on definitional and identification issues; (3) a presentation and discussion of the family context in which emotional maltreatment can occur; and (4) a group exercise and discussion intended to further develop operational definitions of emotional maltreatment.

GOALS:

1. To present the legal and family framework for intervention to protect emotionally maltreated children, in order to help participants to develop the understanding and confidence necessary to take appropriate action on their behalf.
2. To provide participants with an opportunity to draw upon their own experiences to further define the dimensions, possible causes and appropriate actions to take in cases of suspected emotional maltreatment of children, so as to permit translation of the legal obligation to report into practical guidelines for personal and agency decision-making.

OBJECTIVES:

At the conclusion of this unit, participants will be able to:

1. Give the four criteria for guiding identification of suspected emotional maltreatment of children.
2. Give the two basic factors that should lead one to report suspected emotional maltreatment of children.
3. List at least four possible factors that might cause emotional or behavioral problems in children.
4. Describe what a child protective investigation should seek to establish in a case of suspected emotional maltreatment.

RATIONALE:

Emotional maltreatment of children is an inextricable part of the physical abuse, neglect and sexual abuse of children. However, it can occur without any of these physical manifestations. This unit deals with emotional maltreatment as a distinct form of child maltreatment, involving unique and difficult questions relating to definition and identification. It attempts to counter the point of view held by many that emotional maltreatment refers to a form of child abuse and neglect somehow less serious and more subtle than the other forms. The perspective of this unit is that emotional maltreatment is very serious, even life-threatening. Though it *is* difficult to establish cause-effect ties between parental maltreatment of children and children's disturbed behavior, intervention by concerned professionals and paraprofessionals is justified in order for the circumstances causing such behavior to be diagnosed and appropriate help to be provided.

ADDITIONAL STAFF NEEDED:

None

SPACE REQUIREMENTS:

One room large enough to accommodate the total group.

EQUIPMENT:

16 mm. sound film projector
Screen
Extension cord and adapter plug, if necessary
1 large easel and pad of easel paper or newsprint or
Large chalkboard, chalk and eraser
Felt-tip markers
Masking tape

AUDIOVISUALS:

Film: *"Second Chance"*

BEFORE YOU BEGIN:

Get the references to emotional maltreatment of children from your State's reporting law and have them available for the leader presentation in Activity 2. Duplicate necessary materials, including the Resource Paper and list of indicators, for use in Activity 2, if participants do not have their own copies of the **WE CAN HELP Resource Materials.** Preview the film, "Second Chance," and refine discussion questions. Walk through Activity 4, either alone or with a colleague, to be ready to stimulate the brainstorming process.

PARTICIPANTS' MATERIALS:

Resource Paper and List of Indicators: *"Emotional Maltreatment of Children."*

ACTIVITY		TIME	MATERIALS
1.	Film and Discussion	35 min.	Film: Second Chance
2.	Leader Presentation: Definition, Identification and Reporting of Emotional Maltreatment	25 min.	Resource Paper: "Emotional Maltreatment of Children"
	BREAK	10 min.	
3.	Leader Presentation and Discussion: Emotional Maltreatment and the Psychosocial Ecology of the Family	15 min.	Easel Paper, markers
4.	Group Exercise: Brainstorming Emotional Maltreatment Indicators, Causes and Interventions	30 min.	Easel Paper, markers
	Summary	5 min.	

ACTIVITY 1. Film and Discussion.

35 minutes

Introduce unit and activity (2 minutes)

The leader introduces this unit on identifying emotional maltreatment of children by stating the goals of the unit:

1. To present the legal and family framework for intervention to protect emotionally maltreated children, in order to help participants to develop the understanding and confidence necessary to take appropriate action on their behalf.
2. To provide participants with an opportunity to draw upon their own experiences to further define the dimensions, possible causes and appropriate action to take in cases of emotional maltreatment, so that they may translate legal obligations to report into practical guidelines for personal and agency action.

The first activity uses a short film, "Second Chance," which portrays a child being treated in a hospital after emotional maltreatment.

(NOTE: The reason for showing "Second Chance" as the first activity is to emphasize at the outset the real and serious harm to children that emotional maltreatment can cause.)

FILM

Show film (13 minutes)

Discussion:

Discussion (20 minutes)

The leader should first allow participants to share feelings about this film. Then discussion should move to these questions:

1. How would you describe the child's behavior:
   - In terms of observed actions (what she actually did or did not do)?
   - In terms of interpretations of those actions (why she acted as she did)?
2. Is there evidence directly linking the child's behavior to maltreatment on the part of her parents?
3. What treatment appears to have been most effective in improving the child's condition?
4. If no intervention had occurred, what would probably have happened to the child?

Notes can be made on easel paper or the chalkboard as answers to these questions are proposed and discussed.

ACTIVITY 2. Leader Presentation: "Definition, Identification and Reporting of Emotional Maltreatment of Children."

25 minutes

This presentation parallels the resource paper entitled "Emotional Maltreatment of Children" on page 50 of the **WE CAN HELP Resource Materials.** If participants have had a chance to read the paper before the session, this activity may be conducted as a discussion of the points which follow. Otherwise, the leader should present these points and provide an opportunity for questions and discussion.

1. Variety of emotional maltreatment terms

1. Legal definitions of emotional maltreatment use a number of different terms, such as *mental injury, emotional neglect, danger to a child's health and welfare and circumstances injurious to a child's welfare.*

2. State's terminology for emotional maltreatment?

2. The term which refers to emotional maltreatment in our State's reporting law?

____

It is further defined in the law as?

____

____

____

3. Draft Model Child Protection Act definition

3. The Draft Model Child Protection Act uses the term *mental injury* and defines it as "injury to the intellectual or psychological capacity of the child as evidenced by an observable and substantial impairment in his ability to function within a normal range of performance and behavior, with due regard to this culture."

4. Four criteria for identification

4. There are four criteria to guide identification of emotional maltreatment that are contained in the Draft Model Child Protection Act definition.

- It has an effect—causes an injury.
- The effect can be observed in the child's abnormal behavior or performance.
- The effect is lasting rather than temporary.
- The effect constitutes a handicap to the child.

(All of these criteria must be considered within the context of the family's particular culture.)

5. List of behaviors

5. A list of child behaviors and related parent behaviors is provided on page 48 of **WE CAN HELP Resource Materials.** (Participants should be given a few moments to look over the list before going on.) The child behaviors in this list are the *effects* referred to in the criteria for identication.

6. Emotional Assaults

6. Some forms of emotional maltreatment involve obviously harmful emotional assaults on a child. Such forms may include:

- Shutting a child in a dark closet for 24 hours or longer.
- Feeding a child like a pet animal away from other members of the family.
- Tying a child to a bedpost for hours at a time.
- Engaging in bizarre acts of torment or nonphysical torture.

Such emotional assaults require immediate reporting to the child protective authorities so they can intervene to protect the child.

7. Recognition of most emotional maltreatment starts with recognition of effects, but disturbed child behaviors can be the results of other than parental maltreatment.

7. Ambiguous causes of emotional effects

8. Identification of suspected emotional maltreatment requires a meeting with the parent(s) to discuss the child's behavior or performance problems and to suggest possible help to address those problems.

8. Meeting with parents to suggest help for child

9. The parent's response to offers of help can provide a further indicator of possible emotional maltreatment and/or a need for child protective action. Parents may:
   - Agree to get help and follow through to get help (no reporting necessary).
   - Agree to get help, but fail to follow through (report may be necessary if such passive resistence continues).
   - Refuse to get help because of own sense of inadequacy (unless they can be helped to take action to care for child, a report is necessary).
   - Refuse to get help and totally reject outsider intrusion into their family (a report is necessary).

9. Responses to offers of help

10. Reporting and child protective investigation are justified:
    - In cases of serious emotional assault (as in #6 above).
    - When there are emotional effects in the child that *appear* to meet the four criteria above.
    - When the parents refuse or appear to be unable to get help to treat the condition.

10. Reporting

11. Child protective investigation of emotional maltreatment:
    - Gathers information about the needs of the child for help.
    - Gathers information about possible parental behavior causing the child's problem.
    - Determines necessary action to make help available to protect the child from harm.
    - Serves as a bridge to treatment services for the child and the family.
    - Checks the home situation to determine whether other forms of child maltreatment are occurring or other children are endangered.

11. Child protective process and emotional maltreatment

BREAK

10 minutes

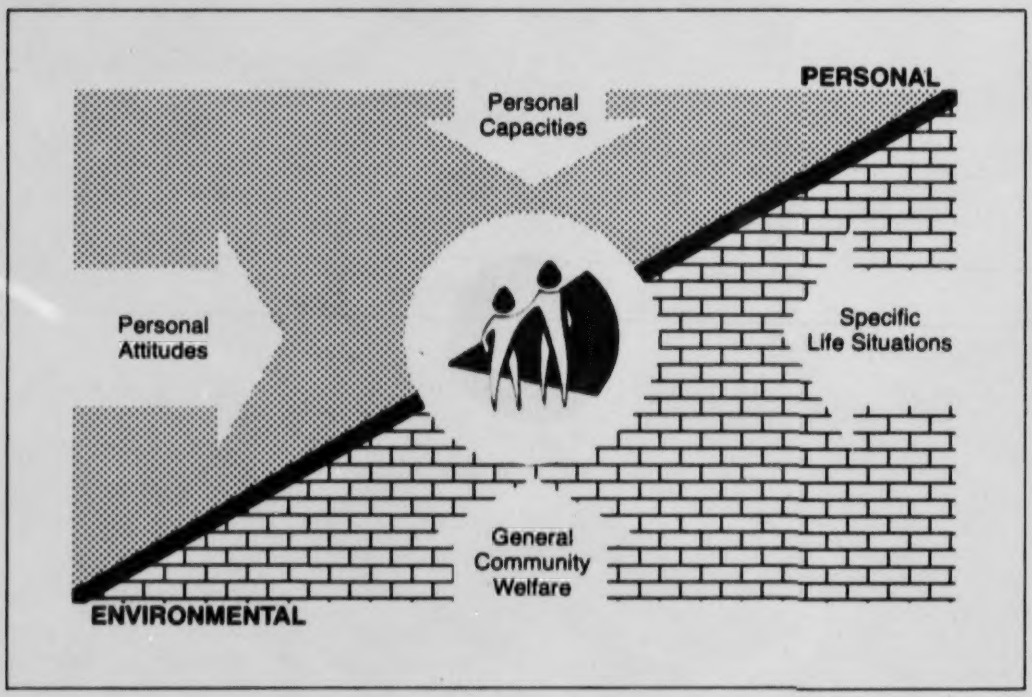
ACTIVITY 3. Leader Presentation and Discussion: Emotional Maltreatment and the Psychosocial Ecology of the Family.

15 minutes

This brief presentation and discussion allow for a review and application of the model presented in the filmstrip and discussion in Unit 1 of **WE CAN HELP.** The leader should put the graphic depiction of the model on easel paper or the chalkboard.

Put model on easel paper or chalkboard

ECOLOGY OF CHILD ABUSE AND NEGLECT



This picture can be helpful in understanding emotional maltreatment and its causal and contributing factors. If the parent-child interaction in the center of the picture is a suspected case of emotional maltreatment, the types of forces that affect all individuals and all families can be looked at more closely to discern what is happening and what might be done about it.

The role of psychosocial forces on parents in cases of suspected emotional maltreatment

For example, one who suspects emotional maltreatment because of a child's disturbed emotional outbursts may ask:

Personal capacities

- What kinds of personal capacities does the parent bring to the parent-child relationship—his or her own emotional health, physical health or intellectual capacities?

Personal beliefs and attitudes

- What beliefs and attitudes does the parent bring to the parent-child relationship—especially in emotional maltreatment situations, what beliefs and attitudes about discipline, religion and morality?

Specific life situations

- What specific life situations are affecting this parent-child relationship? Will they alter without outside intervention so as to change the situation substantially and positively?

Social/institutional forces

- What are the social/institutional forces that may be affecting the parent-child relationship—e.g., school, medical care, social services? Can the effects of these institutions be changed so as to lessen the damaging aspects of the parent's behavior toward the child?

Using the model to guide interpretation of parents' responses when concern about a child is indicated

Keeping these various forces in mind can provide a person who is seeking to understand the dynamics of a child's possible mental injury with guidelines for how to approach a meeting with the child's parent(s). They can help to determine whether official action is required to protect the child from further mental or emotional harm. The concerned professional or paraprofessional can seek the parent's own interpretation of the child's disturbed behavior. The parent's perspective may not be accurate at all, but it will probably provide important clues as to the factors influencing the parent-child relationship.

In addition, the parent's perspective on the child's problem, interpreted in terms of the psychosocial ecology model, can suggest appropriate types of help—medical, psychiatric, psychological for the individual, personal problems which are acting on the parent-child relationship; personal advocacy with social institutions and concrete services for the problems of more environmentally generated situations.

ACTIVITY 4. Group Exercise: Brainstorming Emotional Maltreatment Indicators, Causes and Protective Actions.

30 minutes

The leader puts up a matrix on the chalkboard or easel paper sheets:

Case	Child Indicators	Parental Willingness/Ability to Get Help	Parent Indicators	Hypothetical Possible Causes

Ask for experiences with emotionally disturbed children

The leader then asks anyone in the group to volunteer to briefly describe an experience with a child exhibiting "an observable and substantial impairment in his (or her) ability to function within a normal range of performance and behavior, with due to regard to his culture." The leader should be ready to describe such a case to begin the process, in case the group is reticent about volunteering.

Develop the matrix

After a profile of the experience with a child is *briefly* given by the volunteer or leader, the matrix can be filled out. At the point where facts are not known a parenthesis ( )can be put around the entry on the matrix, but the group should be encouraged to *brainstorm* what might be the case as well as what is actually known about it. These hypothetical entries should include as many possibilities as the group can think of.

(An example is provided on page 142.)

Participants decide what action should be taken

After placing three or four profiles on the matrix, the leader should ask of each one:

- Should this case be reported for further child protective investigation?
- What kinds of diagnostic and treatment services would you recommend?

SUMMARY.

The leader may use the objectives for the unit to lead a brief summary discussion.

1. What are the four criteria for guiding identification of suspected emotional maltreatment of children?
2. What are the two basic factors that should lead one to report suspected emotional maltreatment of children?
3. What are some of the factors that might cause emotional or behavioral problems in children?
4. What should a child protective investigation seek to establish in a case of suspected emotional maltreatment of children?

5 minutes
Use objectives to review unit's material.

SAMPLE

EMOTIONAL MALTREATMENT OF CHILDREN MATRIX

CASE	*CHILD INDICATORS*	*PARENTAL WILLINGNESS/ ABILITY TO GET HELP*	*PARENT INDICATORS*	*HYPOTHETICAL POSSIBLE CAUSES*
John, 6 years old, disruptive in school.	Can't sit still./Can't concentrate./In fights often./Does not produce any school work./Cries easily./Resists individual positive attention and comfort./Nervous-pulls hair, bites nails, moves legs and arms constantly.	Say they are willing to get help, but have not followed through.	"John is always in trouble."/Anger between parents./Anger at John for causing trouble./No signs of affection for John.	(Organic causes.)/ (Failure to form parent-child bond in infancy.)/ (Parental marital discord.)/ (School situation unsuitable.)/ (Lack of child development knowledge on part of parents.)

INDICATORS OF EMOTIONAL MALTREATMENT OF CHILDREN*

CHILD BEHAVIOR		PARENT BEHAVIOR
TOO LITTLE	TOO MUCH	ABUSIVE IF CONSISTENT GROSS FAILURES TO PROVIDE
1. Psycho-social dwarfism, poor self-esteem, self-destructive behavior, apathy, depression, withdrawn	Passive, sheltered, naive, "over-self-esteem"	1. Love (empathy) (Praise, acceptance, self-worth)
2. Academic failure, pseudo-mental retardation, developmental delays, withdrawn	Hyperactivity, driven	2. Stimulation (emotional/cognitive) (talking-feeling-touching)
3. Symbiotic, stranger and separation anxiety	Pseudo-maturity	3. Individuation
4. Lack of integrative ability, disorganization, lack of trust	Rigid-compulsive	4. Stability/permanence/continuity of care
5. Feelings of inadequacy, passive-dependent, poor self-esteem	Pseudo-maturity, role reversal	5. Opportunities and rewards for learning and mastering

6. Autistic, delusional, excessive fantasy, primary process, private (unshared) reality, paranoia	Lack of fantasy, play	6. Adequate standard of reality
7. Tantrums, impulsivity, testing behavior, defiance, antisocial behavior, conduct disorder	Fearful, hyperalert, passive, lack of creativity and exploration	7. Limits, (moral) guidance, consequences for behavior (socialization)
8. Impulsivity, inappropriate aggressive behavior, defiance, sadomasochistic behavior	Passive-aggressive, lack of awareness of anger in self/others	8. Control for/of aggression
9. Interpersonal difficulty (peer/adults), developmental lags, stranger anxiety	Lack of familial attachment, excessive peer dependence	9. Opportunity for extrafamilial experience
10. Poor peer relations, role diffusion, (deviant behavior, depending on behavior modeled)	Stereotyping rigidity, lack of creativity	10. Appropriate (behavior) model
11. Gender confusion, poor peer relations, poor self-esteem	Rigid, stereotyping	11. Gender (sexual) identity model
12. Night terrors, anxiety, excessive fears	Oblivious to hazards and risks, naive	12. (Sense of) (Provision of) security/safety

ABUSIVE IF PRESENT TO A SEVERE DEGREE

1.	Poor self-esteem, depression	1. Scape-goating, ridicule, denigration
2. Rigidity	Lack of purpose, determination, disorganization	2. Ambivalence
3. Poor self-esteem, passivity	Pseudomaturity	3. Inappropriate expectation for behavior/performance
4. (Depends on behavior while intoxicated)		4. Substance abuse
5. (Depends on behavior/type frequency)		5. Psychosis
6. Not applicable	Night terrors, anxiety excessive fears	6. Threats to safety/health
7.	Sadomasochistic behavior, low self-esteem, anxiety, passivity, anti-social behavior, self-destructive dangerous behavior	7 Physical abuse
8.	Anxiety, excessive fear, dependency	8. Threatened withdrawal of love

*Ira S. Laurie, M.D. and Lorraine Tafano, "On Defining Emotional Abuse: Results of an NIMH/NCCAN Workshop,"

EMOTIONAL MALTREATMENT OF CHILDREN

LEGAL DEFINITIONS

The concept of emotional maltreatment of children—or emotional neglect, or mental injury—is a relatively new one. In the past, it was covered in law by such general phrases as "acts or omissions injurious to the child's health or welfare." There has been a recent trend to include emotional maltreatment in the State reporting laws on child abuse and neglect. More than 45 States with such reporting laws refer to emotional maltreatment, using different terms for this form of child abuse or neglect. Among these terms are:

- Mental injury,
- Gross neglect which would affect mental or emotional well-being,
- Emotional abuse, and
- Protracted impairment of emotional health.

In our State, the concept of emotional maltreatment is handled as follows:

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The Draft Model Child Protective Services Act, in an attempt to further explicate the meaning of emotional maltreatment, combines the concepts of parental acts or omissions with consequent harm or threatened harm to the child. It refers to "mental injury" and defines it as "injury to the intellectual or psychological capacity of the child as evidenced by an observable and substantial impairment in his ability to function within a normal range of performance and behavior, with due regard to his culture."

FROM DEFINITION TO IDENTIFICATION

The definition from the Draft Model Child Protection Act implies four criteria that can help to identify possible cases of emotionally maltreated children. These criteria can guide decisions about whether or not action is justified to protect children from emotional maltreatment and to link children who have suffered from it with appropriate remedial services. They can also help to differentiate emotional maltreatment as a category of child abuse and neglect from ineffective or even occasionally harmful parental behaviors toward children.

These four criteria for identification are:

1. **Emotional maltreatment is a parental (or caretaker) pattern of behavior that has an EFFECT on the child.** It causes an emotional or mental *injury*. This criterion may seem obvious, but it should serve as a brake on any intrusive labelling of family interactions which deviate from one's own preferred ways of behaving but do not appear to have harmful effects on the children.
2. **The effect of emotional maltreatment can be OBSERVED in the child's abnormal performance and behavior.** Though emotional maltreatment may be suffered silently and stored away by some children for a behavioral explosion many years later, identification of "symptomless" maltreatment is not legitimate, except in cases of observed, clearly harmful emotional assault. Observation of what one *believes* to be emotionally harmful parental behaviors should properly lead one to offer help to a parent who may be personally in need of it; if the child of that parent happens to be happy, productive and well-adjusted, grounds for child protective action are lacking.
3. **The effect of emotional maltreatment is LONG-LASTING.** It affects the child's intellectual and psychological *capacity*—which is much more serious in its consequences than the kind of temporary or episodic unhappiness, angry acting-out or even regressive infantile responses which parental actions quite often trigger in children. By implication, it is reasonable to add that maltreat-

ment which brings about erosion of a child's capacity to think and to feel is probably a chronic pattern of parental behavior rather than a single or even an occasional lapse on a parent's part.

4. **The effect of emotional maltreatment constitutes a HANDICAP to the child.** It causes *substantial impairment* of the child's ability to function as a normal human being—to think, to learn, to enter into relationships with others and to find satisfaction in one's endeavors.

These criteria for the identification of emotional maltreatment of children serve as guidelines, not as points that must be proved before action is taken on a child's behalf. There is sufficient *reason to believe* that a child who fits these four criteria is suffering from emotional injury.

The common word among these criteria is *effect.* As with other forms of child abuse and neglect, recognition usually starts with *indicators* that something is wrong. Thus, recognition starts with the effects or symptoms of effects. To those who have little opportunity to observe parent-child interactions over an extended period, the indicators of emotional maltreatment are exhibited by the child. These indicators are almost always more ambiguous than indicators in cases of physical maltreatment. Parental behaviors are *not* the cause of all of children's behavior problems or intellectual impairments. Medical science has made important advances in isolating physical causes and in pharmaceutical treatments for many emotional disorders and "mental injuries" which earlier observers would have blamed on parental neglect or severity in relating to those children. On the other hand, children's behavior can indicate cruel or negligent treatment unaccompanied by bruises, welts, broken bones or signs of malnutrition. That a child is in emotional trouble is no clear indication of *why* a child is in trouble.

Before a suspicion of emotional maltreatment can be properly formulated, an additional step—beyond noting the as yet unexplained symptoms in the child's behavior—is appropriate. That step is to talk with the parent(s) about the child's behavioral or performance problems, and, if possible, to observe the way the parent(s) and child interact.

Some parents will readily agree that help is needed and offer to follow up on referrals for special services, such as medical examination, remedial education, psychiatric treatment, family therapy or parent education programs. They should be supported in making the necessary contacts. No report of suspected emotional maltreatment is indicated in such instances—*unless* they fail to follow through on their agreement to get help.

Some parents may agree to seek help for their child but fail, despite repeated reminders and concerned inquiries, to follow through on that agreement. Whatever their reasons for such passive resistance, a report will be necessary to insure that the child receives the needed help.

Some parents will express sincere concern about their child's problem but may not offer cooperation in seeking help—out of fear or a sense of their own inadequacy or an inability to pay for the recommended services. If such parents cannot be persuaded to get the needed services, a report to the Child Protection Agency is appropriate, to allow an agency with legal sanction to intervene on the child's behalf and, through appropriate use of its authority, to persuade parents or even get a court's mandate to insure that attention is given to the child's problem.

Still other parents may completely refuse to cooperate, even to discuss the child's need for skilled attention to an emotional or behavioral problem. Their response will probably be some version of "mind your own business." For the concerned observer to report to the Child Protection Agency, with full information about any attempts to confer with the parents, is clearly appropriate in such circumstances. A child protective investigation may find a frustrated, fearful parent with a child suffering from some kind of somatogenic emotional disturbance or, more probably, with a child whose own emotional instability or learning problem is a reflection of trauma to the entire family such as marital separation, unemployment and financial insecurity or a death in the family. But, in many instances, the investigation will bring to light a situation in which the child (and perhaps the child's siblings) has become the target of spiteful scapegoating, constant belittling, deliberate and enforced isolation or continuous withholding of the security, affection and "developmental space" that children need in order to develop normally.*

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*The concept of "developmental space" comes from workshop material presented by Ira S. Lourie, M.D.

CHILD PROTECTION IN CASES OF EMOTIONAL MALTREATMENT

The child protective investigation of a suspected emotional maltreatment report involves the difficult task of determining any linkages between the child's abnormal behavior and parental acts or omissions. The investigating worker will also discuss with the parent(s) the child's need for help and offer to assist them in getting that help. The added ingredient in this interview with parents is authority—the legally sanctioned power of the worker to take action on the child's behalf against parental wishes. If help is rejected and if there is evidence of *parental behaviors* that are causing substantial impairment to the child's intellectual and emotional capacity, the worker can seek court action that at least will allow for a more in-depth assessment by a mental health professional. If the linkage is clear enough and can be affirmed by expert testimony based on observation and psychiatric assessments, court action may extend to a finding of child maltreatment and orders mandating treatment services or even placement of the child in a substitute home.

As in the case of physical abuse, neglect and sexual abuse, concern about emotional maltreatment of children is primarily aimed at protecting children, not at blaming parents. In the first instance, identification of children with "substantial impairment in . . . ability to function within a normal range of performance and behavior" provides an opportunity to offer help—help to better understand the child's problem and to discover the underlying factors that may be causing it. The child protective process must be called into action, through an official report of suspected child abuse or neglect, when that opportunity is rejected by the adults responsible for the child's welfare.

In summary then, identification of emotional maltreatment is indicated when:

1. A child is showing substantial impairment of emotional or intellectual capacity and
2. The parents/caretakers appear to show an inability or unwillingness to get help for the child when such help is offered.*

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*This formulation is paraphrased from workshop material developed by Michael A. Nunno and James Cameron.

Unit 5:

CHILD SEXUAL ABUSE

UNIT 5

Time: 2 hours 15 minutes
Optional—3 hours

CHILD SEXUAL ABUSE

DESCRIPTION:

This unit presents information about intrafamilial sexual abuse of children. It contains: (1) activities to sensitize participants to the ramifications of child sexual abuse and to their own attitudes and responses; (2) presentations of information on definitions, indicators and family dynamics; (3) optional audiovisual presentations for specific professional audiences on dealing with cases; and (4) presentation and discussion of ways to help in the child protective process in cases of sexual abuse.

GOALS:

1. To introduce participants to the problem of intrafamilial child sexual abuse from the perspective of the victim, so they may recognize its potentially serious effects.
2. To enable participants to explore their own attitudes about child sexual abuse and to consider the impact of these attitudes on their ability to respond appropriately to suspected cases.
3. To provide information on definitions and indicators of child sexual abuse.
4. To define basic guidelines for intervention in suspected cases of child sexual abuse in order to get protection for child victims and help for their families.

OBJECTIVES:

At the conclusion of this unit, participants will be able to:

1. Give a general definition of child sexual abuse.
2. List four physical and four behavioral indicators of child sexual abuse.
3. Describe two ways the legal and child protective system can actually increase the emotional trauma of child sexual abuse.
4. List three suggestions for helping the child who may be a victim of sexual abuse.

RATIONALE:

Intrafamilial child sexual abuse is a form of child maltreatment which involves different dynamics, different case-finding and different procedures of child protective intervention. While it is covered by child abuse and neglect reporting laws and can be handled as a juvenile (civil) court matter, child sexual abuse is also included under criminal statutes as a sex offense and cases may be taken to criminal court for prosecution of the perpetrator. The response of those who discover cases, of the agencies involved in handling them and of the community at large may be more reflective of personal attitudes toward the crime than of concern for the protection and emotional well-being of the child victims. The intent of this unit is to assist participants in clarifying their own attitudes and directing their attention to the victims, perpetrators and families involved in child sexual abuse, while also providing a factual framework for recognizing the problem and taking action.

ADDITIONAL STAFF NEEDED:

None

SPACE REQUIREMENTS:

One room large enough to accommodate total group.

EQUIPMENT:

1 easel board and pad of easel paper or chalkboard
Felt-tip, markers or chalk and eraser
(Optional) 16 mm sound film projector
35 mm filmstrip projector and cassette tape recorder
Screen.
Extension cord and adapter plug, if necessary.

AUDIOVISUALS:

(Optional) Film: *"Sexual Abuse: The Family"*

ACTIVITY	TIME	MATERIALS
1. "What It Was Like To Be An Incest Victim"	15 min.	Reading
2. Group Exercise: Feelings About Child Sexual Abuse	15 min.	
3. Dyad Exercise: Attitudes	30 min.	
4. Presentation: "Definitions and Indicators of Child Sexual Abuse"	20 min.	Resource paper: "Sexual Abuse of Children"
BREAK	10 min.	
5a (Optional) Filmstrip: "Medical Indicators of Sexual Abuse" (for physician or nurse participants)	30 min.	Filmstrip: "Medical Indicators of Child Abuse and Neglect: Part 5—Sexual Abuse"
5b (Optional) Film: "Sexual Abuse: The Family" (for social work, medical or law enforcement participants)	45 min.	Film: "Sexual Abuse—The Family"
6. Presentation: "Helping in Cases of Suspected Child Sexual Abuse"	40 min.	Resource paper: "Guidelines for Interviewing Children"
7. SUMMARY	5 min.	

(Optional) Filmstrip/cassette: *"Medical Indicators of Child Abuse and Neglect—Part 5: Sexual Abuse"*

BEFORE YOU BEGIN:

Preview the film and filmstrip and decide whether either should be used with your training audience. Duplicate any necessary materials, if copies of **WE CAN HELP Resource Materials** are not available for participants. Choose a reader for "What It was Like to Be an Incest Victim," if you do not intend to read it yourself, and ask the reader to prepare by reading it over in advance. Be sure to have your State child abuse reporting and/or criminal statute's definition of child sexual abuse available for Activity 4.

PARTICIPANTS' MATERIALS:

Resource Paper *"Sexual Abuse of Children"*
"Guidelines for Interviewing Children"

ACTIVITIES

ACTIVITY 1. "What It Was Like To Be An Incest Victim"

15 minutes

Goals of the unit

The leader introduces this unit on child sexual abuse by listing the goals of the unit:

1. To introduce participants to the problem of intrafamilial child sexual abuse from the perspective of the victim so they may recognize its seriousness.
2. To enable participants to explore their own attitudes about child sexual abuse and to consider the impact of these attitudes on their ability to respond appropriately to suspected cases.
3. To provide information on definitions and indicators of child sexual abuse.
4. To define basic guidelines for intervention in suspected cases of child abuse in order to get protection for child victims and help for their families.

Focus in unit on intrafamily sexual abuse.

The leader points out that the focus of this unit is entirely on intrafamilial child sexual abuse. Sexual abuse of children by strangers falls primarily within the jurisdiction of law enforcement and is not usually considered a child protective issue unless it involves parental negligence or participatory abuse (such as soliciting children for prostitution or pornographic purposes). Sexual abuse perpetrated by a parent or caretaker of a child is included both in child abuse and neglect reporting statutes and falls within the responsibilities of child protective services.

The leader then reads (or has a participant, who has had an opportunity to prepare in advance, read) the anonymous testimony of a 13-year-old girl, "What It Was Like To Be An Incest Victim," on page 159. After the reading, the leader moves directly to Activity 2.

ACTIVITY 2. FEELINGS ABOUT CHILD SEXUAL ABUSE

15 minutes

Brainstorm reactions to child sexual abuse

The leader points out that sexual abuse of children, particularly intrafamilial sexual abuse, generates intense reactions in most adults, no matter what their professional roles. This simple exercise calls for participants to "brainstorm" those reactions. Participants should be asked to give words or phrases that describe typical reactions. The leader should write these words or phrases on easel paper or the chalkboard, placing words which convey disgust, anger or other "negative" emotions on one side and those which convey empathy and concern on the other.

Consider list of reactions

After about 10 minutes of brainstorming, the leader should point out the imbalance of the lists and ask participants to consider whether a similar imbalance would have existed if the subject had been child abuse or child neglect.

Purpose of exercise to expose possible barriers to learning

The importance of verbalizing these reactions at the beginning of this session is that, unless they are recognized, they may form barriers to learning about this subject and impede the likelihood that participants will take helpful protective action in suspected cases.

ACTIVITY 3. DYAD EXERCISE: Attitudes

30 minutes

Attitudes toward sex as a barrier to learning and action

Just as shock, outrage or disgust can block effective understanding or action related to child sexual abuse, so one's own attitudes and sexual experiences can also be barriers. This exercise gives participants a chance "to get in touch with" these attitudes, without necessarily baring private information or feelings.

Choose dyad partners

The leader asks participants to choose partners. Each person is to talk to the other on the topics given by the leader. One person talks, while the other listens, without interrupting. After three to five minutes, the leader will ask the dyads to exchange roles so that each person will have an opportunity to talk.

The leader asks participants to move their chairs to allow for a dyad conversation. Then the leader announces the first topic:

How I learned about sex

- How I first learned about sex.

After a *maximum* of six minutes (three minutes for each partner), the leader announces the second topic:

Uncomfortable experience with older person

- An experience with an older person that caused me to feel uncomfortable because of sexual overtones.

Discuss generalizations

The experience of being vulnerable

The leader should reconvene the group and invite discussion of the exercise. The discussion should focus on generalizations about attitudes rather than continue individual reflections on the two topics. (For example, what are the major ways children learn about sex? What kinds of situations typically generate those uncomfortable feeling? A generalization from the second topic that is most relevant to child sexual abuse has to do with feelings of being vulnerable—of someone having power over a younger person. If such experiences can cause emotional discomfort in chance or occasional relationships, the problem is escalated in the case of a child who becomes the target of sexual attentions of a parent.

ACTIVITY 4. LEADER PRESENTATION: "Definitions and Indicators of Child Sexual Abuse"

20 minutes

Refer to Resource Paper

The leader should refer participants to the resource paper, "Sexual Abuse of Children," on page 55 of **WE CAN HELP Resource Materials.** The following presentation outline can be expanded by using the first four sections of the resource paper. If participants have had an opportunity to read the resource paper in advance of this session, they may wish to discuss points it raises.

The main points to be made in this presentation are:

1. Definition

1. Intrafamilial child sexual abuse may be defined as contacts or interactions between a child and an adult

in which the child is being used for the sexual stimulation of the adult or another person. Sexual abuse may also be committed by a person under the age of 18 when that person is either significantly older than the victim or when the perpetrator is in a position of power or control over another child.

2. State law definition

2. The definition of child sexual abuse contained in our State child abuse and neglect reporting law is (if it is defined):

3. Victims-Perpetrators

3. While the victims of intrafamilial sexual abuse may be boys and the perpetrators may be adult women, most *reported* cases involve girls and fathers, father-substitutes or other male adult family members. It may be that boys are more reluctant than girls to report. The average age of children in one study conducted by the American Humane Association was 11 years. Many treatment projects report that the abuse actually begins several years earlier.

4. Adult use of child for sexual gratification

4. Physically violent sexual abuse within the family, such as rape and sadism, is rare. Usually the context of the abuse is a parent-child relationship, which may begin "innocently" as special physical attention from the parent figure and develop into a relationship of adult sexual gratification at the child's expense. In some but certainly not all cases, the mother is aware of the sexual abuse but denies or ignores its existence.

5. Possible underlying characteristics

5. The family dynamics that contribute to sexual abuse of a child are complex. The underlying characteristics may include:

- A father or stepfather who is ineffectual, has low self-esteem, and is unable to relate adequately to other adults. He may be an autocratic ruler of the family.
- An unhealthy marital relationship, in which the adult sexual relationship is either strained or nonexistent.
- Prolonged absence or loss of one parent.
- Severe overcrowding.
- Lack of social and emotional contacts outside the family.
- Geographical isolation.
- Alcoholism
- Precipitating crisis in adult's life with a resulting loss of self-esteem.
- Presence of an extremely passive parent.
- Cultural attitudes and multigenerational patterns of incest.

6. Physical indicators

6. Physical indicators of child sexual abuse include:

(Nonmedical observation)
- Pain, itching, bleeding in genital area.
- Torn or stained clothing.
- Genital, anal or oral bruises.

(Medical observation)
- Genital, anal or oral bruises.
- Genital, anal or oral bleeding.
- Swollen or red cervix, vulva or perineum.
- Semen on genitals or clothing.
- Veneral disease—oral/genital.

(See Optional Activity 5 below)

7. Behavioral indicators

7. Behavioral indicators include:
   - Regressive or fantasy behavior, night fears.
   - Extreme withdrawal or agression.
   - Sexual acting out or promiscuity.
   - Poor peer relationships.
   - Fear of opposite sex.
   - Extremely protective parental behavior.
   - Avoidance of physical activity.
   - Running away from home.
   - Drug abuse.
   - Self-destructive behavior/self-mutilation.
   - Indirect allusions to problems at home.
   - Psychosomatic illnesses.

8. Effects of sexual abuse vary

8. The effects on the child of sexual abuse vary depending upon factors such as:
   - Child's age and developmental status.
   - Relationship of the perpetrator to the child.
   - Amount of force or violence used.
   - Degree of shame or guilt evoked in the child for her participation.
   - Reactions of the parents to the discovery.
   - *Reactions of those professionals who become involved in the case.*
9. While the physical and emotional trauma caused by sexual abuse itself may vary, it is clear that the way professionals handle a discovered case can have lasting effects on the child and the family. The community's outrage at child sexual abuse may be translated into criminal prosecution that depends upon evidence given by the victim. A frightened child becomes the center of a storm of family and professional intervention which threatens to disintegrate her family in the interest of protecting her from further sexual abuse.

BREAK — **10 minutes**

(OPTIONAL ACTIVITIES)

ACTIVITY 5A FILMSTRIP: "Medical Indicators of Sexual Abuse"

30 minutes

Activity audience
Introduce filmstrip

This optional activity is recommended for use with medical professionals. It outlines both medical indicators of child sexual abuse and recommends diagnostic and examination measures that should be followed in suspected cases.

FILMSTRIP — **Show filmstrip (15 min.)**

Discussion:

Discussion

The leader should guide the discussion of the filmstrip to insure that these points were communicated to participants:

Points to emphasize

1. Children come to examination for sexual abuse usually because they have confided in a third party, sometimes long after the incident.
2. Much of the emotional trauma of sexual abuse can be minimized by changing the way professionals react to it.
3. The child who is brought for a medical examination should not be left alone; the interview should not be conducted in the parents' presence.
4. The child should be interviewed *only once by only one person.*
5. The examiner must use words that the child understands.
6. Only necessary examination procedures should be conducted.
7. Laboratory tests should be conducted, labelled and filed carefully for possible use in court as evidence.
8. Help should be extended to the family as well as the child.

ACTIVITY 5B FILM: "Sexual Abuse—The Family"

45 minutes

Activity audience

This film may be used with an audience composed primarily of law enforcement, medical and social work/child protective worker participants.

Introduce purpose and content of film

The leader introduces film as a documentary that features a discussion of common myths, physical and behavioral indicators, family dynamics and how to conduct an examination. The longest single segment of this film presents "live action" role-playing by staff of the Children's Hospital National Medical Center (Washington, D.C.) and the D.C. Metropolitan Police. The role-playing is a *practice session* for the staff persons on how to respond to a case of child sexual molestation presented at the hospital. The audience is being invited to watch other professionals involved in a learning process, rather than a carefully staged dramatization of a model for professional practice.

FILM

Show film (30 minutes)

Discussion:

Discussion

Here are some of the points the leader may wish to make before participants begin discussing the film:

1. Role-play for critical discussion

1. The role-playing was a portrayal of professionals practicing their roles in order to be able to handle their responsibilities more effectively when actually confronted by a family in which child sexual molestation has occurred. A careful critique of the ways they handled their roles is very much in order. In the training setting at Children's Hospital National Medical Center, the participants and their colleagues would have conducted such a critique of themselves.

2. The necessity for a police or child protective worker to interview the child, and a subsequent formal statement by the child, reflects the law in the District of Columbia (and in many other jurisdictions). While psychological wisdom might indicate that the child should be protected from having to recount the incident over and over, the film depicts legal and practical reality.

2. Police or CPS interviews are present legal reality

3. The role-playing does not depict a case of parent-child incest. Obviously, such a case involves a different set of family dynamics. The leader may want to lead the participants in a discussion of what differences and similarities a case of father-daughter incest would be likely to present, in terms of the behaviors of father, daughter, and mother; and in terms of the responses and approaches required by the professionals involved.

3. Comparison of film case with parent-child incest

4. Among many professionals, the presence of the child at the initial interview of the parents by the resident physician may raise an issue of what is best professional practice. Resolution of this issue may not be possible in many groups, in which different perspectives lead to different conclusions about what should be or can be the best guidelines for professional practice. The leader should expect this issue to arise and be ready to handle a discussion which may not end with consensus.

4. Presence of child in interview with parents

ACTIVITY 6. LEADER PRESENTATION AND DISCUSSION: "Helping in Cases of Suspected Child Sexual Abuse"

40 minutes

This presentation and discussion is based, in part, on material from the last three sections of the resource paper, "Sexual Abuse of Children," beginning on page 55 of **WE CAN HELP Resource Materials.** The leader may present the main points from the section entitled "Victims of the System." Then participants should be given time to read the section entitled "Prescriptions for Change." Finally, the leader should refer participants to the single-page guide entitled "Guidelines for Interviewing Children" and continue the presentation on guidelines for intervention.

Activity based on Resource Paper

1. The discovery of child sexual abuse almost always provokes a jarring crisis in the family involved. The impact of the system's response is often the cause of emotional damage as bad as, or worse than, the abuse itself.

1. Discovery causes family crisis

2. The investigation, starting with the first contacts between the child or the family and an outsider whose purpose is to find out if the child has been sexually abused, can be an overwhelming experience. It often requires the child and parents to recount their stories over and over again to different people beginning with the one who discovers the case and continuing to law enforcement officials, child protective workers, medical staff, mental health professionals, prosecutors, and so forth.

2. Investigation process may involve repeated interviews

3. In the event that a decision is made to press criminal charges, the child may be the key witness, required to "confront the defendant" with her testimony in open court and subjected to cross-examination.

3. Criminal prosecution may require child as witness

4. The only recourse available in many communities is separation of the perpetrator from the abused. The child, in most cases, will be the one removed from the home and placed in foster care. Temporary foster care can be a positive respite for the child victim.

4. Separation

5. It is not surprising that in some cases the child, in an attempt to relieve the strain of investigation on herself and her family, will retract her earlier statement. In such instances, societal intervention that has occurred in the interim has proved more upsetting than continued submission to sexual abuse at home.

5. The child who retracts her charges

6. Programs being developed in communities around the country are designed to change the behavior of intrafamilial child sexual abuse perpetrators, treat the emotional effects of incest on child victims and other family members, and maintain the family unit intact.

6. Treatment programs

At this point, the leader asks participants to read (or review) the section entitled "Prescriptions for Change," in "Sexual Abuse of Children" on page 66 of **WE CAN HELP Resource Material.**

Have participants read "Prescriptions for Change" (10 minutes)

Discussion:

Discussion (10 min.)

Participants should be invited to discuss the material they have read, with particular focus on how the system handles cases of child sexual abuse in their own communities.

The concluding presentation should address these key points:

(10 minutes)

The admonition in the Resource Paper—"First, do no harm"—applies to those who are the first to learn that a child may be the victim of sexual abuse. These guidelines are offered for their use.

"First, do no harm"—Guidelines

1. *Protection for the child is the most important concern.* All cases of suspected or confirmed child sexual abuse should be reported to child protective services. Child protective services will decide whether the case is founded and whether it is one which should be handled by law enforcement alone, jointly with law enforcement or by child protective services alone.

1. Protect the child

2. If a child confides in you about sexual abuse, the child probably trusts you; listen carefully and nonjudgmentally to what the child has to say and explain what actions you are going to take on her behalf and why.
   - Don't act shocked.
   - Indicate immediately that you believe the child.
   - Express concern, but don't press for every detail.
   - Relay the clear message that it was not the child's fault or responsibility.

2. When a child confides

149

3. Third party report

3. If a third party reports a possible case of sexual abuse, the child should be talked with preferably by someone of the same sex whom the child trusts. The purpose is to find out if the child needs to be protected from sexual abuse.

4. Refer to "Guidelines for Interviewing Children"

4. "Guidelines for Interviewing Children" on page 71 of **WE CAN HELP Resource Materials** are useful suggestions.

WHEN TALKING WITH THE CHILD

DO:

- Make sure the interviewer is someone the child trusts.
- Conduct the interview in private.
- Sit next to the child, not across a table or desk.
- Conduct the interview in language the child understands.
- Ask the child neutrally to clarify words or terms not understood which seem key.
- Tell the child if any future action will be required.

DON'T:

- Allow the child to feel "in trouble" or "at fault."
- Disparage or criticize the child's choice of words or language.
- Suggest answers to the child.
- Probe or press for answers the child is unwilling to give.
- Display shock or disapproval of parents, child, or the situation.
- Force the child to remove clothing.
- Conduct the interview with a group of interviewers.
- Leave the child alone with a stranger.

5. Offer continuing help

5. Offer continuing help:
    - To the child, who may need a trusted supporter during the investigation period.
    - To child protective services, which may need you as a member of a "team" approach to providing protection for the child and help for the family.

6. Advocacy

6. Advocate in your community:
    - For more humane, effective procedures for handling cases of child sexual abuse.
    - For the development of treatment programs for victims and perpetrators of child sexual abuse.
    - For outreach programs which offer child victims a chance to seek help early.

SUMMARY

5 minutes
Summarize with unit objectives

The leader should summarize this session by using the unit's objectives as a guide for a brief review of:

1. A general definition of child sexual abuse.
2. Physical and behavioral indicators.
3. Ways the legal and child protective system may increase or decrease emotional trauma.
4. Suggestions for helping the child who may be a victim.

"What It Was Like To Be An Incest Victim"

Anonymous

I am thirteen years old. I was eleven the first time it happened. My mother was out, but the other kids were upstairs. It was evening. My father had been out drinking. I was in bed. He'd been kind of feeling around before that. He'd pat me when I was in my pajamas and stuff like that. I didn't like it. I felt ashamed. That first time, he came in and started feeling under my pajamas. I was half asleep and didn't know what was happening. He was drunk, and, when he's drunk, he's scary. Before I knew it, he was on top of me, and I kept telling him no, but he said he'd hurt me if I didn't do it. I told him I didn't want to, but he said yes, I'd like it, and he was just showing me how. I didn't like it. It hurt. He was dirty. I don't remember much about it really. I don't want to.

He told me not to tell my mother. But then, he did it again and again. I didn't know what to do. He came in maybe once or twice a week. Sometimes, he'd come right from my mother. I could hear them, and then he'd come in and make me do it. I don't know why I let it go on so long. I feel ashamed. I was so scared, and I was afraid someone would find out. I got really withdrawn and down. My school work was okay, but I didn't make any friends. I just worried all the time.

It was two years before I couldn't stand it any longer, and I told my mother. She told me to tell her if it happened again. I told her it had been going on for a long time, and she got mad. She and my father called me a whore. My mother didn't seem to care. Finally, I just had to do something, and I told my counselor at school. She took me to the police. There was this man there . . . I was supposed to talk to a woman, but she wasn't there, and I had to tell all this to the policeman. I was scared. Later, I had to go to a doctor. He got me on this table and used that cold thing. It was just awful . . . worse than the stuff with my father. I didn't know anything about sex. My mother never told me, and I never had a boyfriend or anything. I still wonder. I worried about getting pregnant; I knew enough to know I could. I still don't know why I didn't. The doctor said I wouldn't.

Now I live in a foster home. I was glad to get away from both my mother and my father. The worst part of it is that after I did tell about it, it seemed like it was all my fault. Sometimes, I think it was. Why didn't I stop it? I used to get extra things from my father for being so nice to him, but it wasn't worth it. I never care about seeing him again. My mom doesn't want to leave my dad. I don't think she's happy with him, but she's too scared to be on her own. That's one reason I'd *like* to go back home, so I could help her. But I don't know if she really wants me. She didn't seem to care what was happening to me at all. She just blamed me for everything. I think she needs some counseling, too.

I like it in this foster home. They're really nice here. My dad never used to let me go out. I was only supposed to go to school, go home, and work. Now I get to go out with the other girls at school; we go rollerskating and stuff, and it's fun. But I still flinch if a man touches me. I hate men. Men are dirty; all they want is sex. I'll never marry. I'll adopt children. I like kids.

In fact, that's one of the things that bothers me a lot. I miss my little brothers and sisters, and I know they miss me. I worry about them and feel bad that I'm not home to take care of them. When dad drinks, he gets really mean with them. He hits them with the belt. I want him to get treatment. I don't want him to go to jail. But I don't feel bad about reporting him. I just couldn't stand it anymore. And besides, I'm worried about my sisters. I think he might try something with them, too.

Resource Paper:
SEXUAL ABUSE OF CHILDREN

By Kee MacFarlane

Growing interest and social action on behalf of battered children over the past 10 years have highlighted an even more distasteful form of child victimization. Long believed to be extremely rare, or a problem occurring only in primative cultures or lower classes, sexual abuse of children is now recognized as far more prevalent than once imagined. Hard data on the subject are scarce, but many signs, including increased public awareness and reporting, indicate that it is a problem which is more widespread, more serious, and more difficult to discuss than many other similarly sensitive social issues. While many social problems are as complex as child sexual abuse, few are as distressing.

Disturbing as the actual experience of sexual victimization may be for a child, the long-term effects of that victimization may hold the greatest significance for the child and for society as a whole. It is an experience that, even by the most conservative estimates, probably shapes the lives of thousands of women each year. For the victims of child sexual abuse, like those of rape, spouse battering, commercial sexual exploitation, and a number of other forms of victimization, are overwhelmingly female. The feminine pronoun is used throughout this chapter because child sexual abuse is, in fact, primarily the victimization of young girls.

Child sexual abuse can also be recognized as a fundamental betrayal of childhood trust and an affirmation of the powerlessness of being young and female in a society where victimization is often not recognized and protection is not guaranteed. Most child victims of sexual abuse are not attacked by sick strangers who appear from the shadows when a child is out alone. They are abused, for the most part, by men whom they know and trust. Their exploitation is usually at the hands of their own fathers, family members, or other familiar adults. Moreover, they are generally not physically harmed because their fear, their trust, and their deference to male authority preclude the need for violence. Most children are unprepared and unable to protect themselves against what is perceived as adult prerogative. As a result, many of them internalize their roles as victims within the sexual relationship and in the broader context of their own worlds.

It is instilling of this "victim mentality" in the mind and the developing personality of a young girl that is, perhaps, the most insidious aspect of her sexual exploitation. It is not only pervasive in the many areas of her life in which it may be reenacted, it is an extremely difficult self-concept to change and can be a devastating source of continued self-depreciation.

Almost every society contains cultural taboos against incest and sexual abuse of its children, yet the problem of child sexual abuse has always existed. It is a problem with "a long past but a short history," one surrounded by myth and misconception, by ideas we must dispel in favor of a more disturbing reality if we are to move toward protection of the thousands of children who are its victims.

The universal revulsion felt toward acts of child sexual assault and the strong emotional reaction of most people toward the adult who sexually abuses a child are rarely coupled with an understanding of the problem, its causes, or its effects. This lack of knowledge, shared by professionals and lay persons alike, appears to result from at least three major factors: the scarcity of published research, clinical data, or case material on the subject; the accepted sanctity of matters that happen within, or directly affect the family; and the aura of secrecy that has traditionally surrounded this subject and sexuality in general. In addition, traditionally held beliefs and cultural taboos have fostered fears and reactions toward child sexual abuse that are largely unfounded and misdirected, and that contribute to the inappropriate responses often accompanying its discovery.

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The existing research and literature dealing with the subject of child sexual abuse is so limited, and the number of cases studied so small, that they must be regarded as presenting a largely nonrepresentative picture of the problem. Therefore, although this chapter has drawn on material from existing literature, the reader is cautioned against the temptation to generalize from it to all situations of sexual abuse.

The first step in confronting any social problem involves developing an understanding of the situation, those involved, and the dynamics that support it. Needed is knowledge of all the forces that influence those involved—the ones that motivate people as well as those that keep them from acting.

Sexual abuse reaches deeply into the lives of women as child victims, as mothers who see their daughters victimized, as adolescents whose development is shaped by the experience, and as adults whose sense of identity may be irrevocably marred by their inability to shed the memory of their early exploitation. The victims of childhood sexual abuse represent a population whose long-term vulnerability should not be minimized. They have experienced a betrayal of the most fundamental tenet of an adult-child relationship, and while many have successfully overcome the experience, for others the costs are immeasurable. Those who seek to help such children and their families must consider well the impact of their own actions. They must arm themselves against overreaction and insure that remedial action is always in the best interest of the child.

CHILD SEXUAL ABUSE-DEFINITIONS

One of the difficulties encountered in any discussion of child sexual abuse involves the definition of terms. The term "sexual assault" brings to the minds of many people an image of sexual violence and physical attack. While such incidents do occur and periodically capture our attention in sensational newspaper headlines, they actually represent only a small proportion of the reported incidence of child sexual abuse. The fact is that sexual abuse of children takes many forms, involves varying degrees of violence and emotional traumatization, and is defined in a variety of ways, depending upon the source, context, and purpose of the definition.

Our laws provide little insight into the definitional issues of sexual abuse since there is little uniformity in States' legal definitions. State laws prohibiting incest vary considerably in definition and detail. The penalties for incest range in severity from simple fines to fifty years in prison. Some laws developed out of an initial concern for the production of biologically defective offspring; such laws recognize incest only as sexual intercourse among consanguineous, or blood, relations. Other states, however, reflect the current sociological and psychological trend which recognizes that sexual relations between children and close family members create an atmosphere deleterious to the healthy personality development of the child and interfere with normal family functioning (Tormes, 1967). In these States, incest is recognized as occurring between a variety of family members related by blood and/or law, including adoptive or step-parents, siblings, stepsiblings (in certain cases), and grandparents.

Statutes relating to the sexual assault of children are found in both the criminal codes and the civil codes of most states. The former generally represent a judicial focus on the behavior, conviction, and punishment of the perpetrator, while the latter usually reflect an orientation toward child protection and therapeutic intervention. Whether a sexual abuse case is brought before the civil or criminal court is highly dependent upon who is making that decision, and is the object of considerable debate. The decision to try a sexual abuse case in a criminal or a civil court often depends as much upon such questions as the extent of evidence available or the immaturity of the witness as upon the nature or degree of what was actually done to the child.

Since passage of the Federal Child Abuse Prevention and Treatment Act of 1974, more and more states are specifically requiring the reporting of sexual abuse and a degree of uniformity is being established with regard to who is legally responsible for reporting the different types of child abuse. Yet the definition of what constitutes the physical, emotional, and sexual abuse of children still remains largely a matter of jurisdictional and individual interpretation. Furthermore, since most reporting laws address themselves to child abuse by parents or persons legally responsible for a child's welfare, an act of sexual abuse committed by a person outside the family may be defined and handled quite differently from the same act committed by someone legally responsible for the child.

As an example of the different terminology used, in the State of California, the definition of abuse includes: compelling illicit relation by menance, abduction to force defilement, incest, sodomy, sexual contact, assignation or procuring female by force or false inducement, oral sex perversion, seduction, exciting the lust of a child, and so on. To complicate matters even further, the sexual abuse of children is often defined not only in terms of what is done to the child, but the victim's age and the relationship of the abuser of the child are also taken into account. New York State law defines degrees in the crime of sexual abuse with different penalties for each crime. For example, an act of sexual abuse is treated differently: if the victim is less than 11 years old, if the victim is under 14 years old, if sexual contact is without the subject's consent, or if the offender is less than five years older than the subject. Sexual abuse has been imprecisely defined as: "A person is guilty of sexual abuse when he subjects another person to sexual contact." Many State laws provide little guidance as to the meaning of the words "sexual abuse," preferring to leave the matter of interpretation to the courts (McKerrow, 1973:40).

While practitioners and law enforcement officers may bemoan the lack of a specific definition for child sexual abuse, the problem is obviously too complex to lend itself to a simple operational definition. This chapter, therefore, will take a rather generic approach to the issue of child sexual assault. For purposes of this discussion, the terms "sexual abuse" and "child sexual assault" will be used to mean those sexual contacts or interactions between a child and an adult who is attempting to gratify his or her sexual needs or desires.

SCOPE OF THE PROBLEM

The sexual abuse of children is not a new problem; references to its occurrence date back to Old Testament times. Moreover, it is not as rare a phenomenon as many people would like to believe. But child sexual abuse, like rape, is one of the most underreported crimes in our society. Although estimates of its frequency vary, those cases of sexual abuse that are officially reported to appropriate authorities clearly represent only a fraction of the cases that actually occur.

Statistics from the American Humane Association's study of official reports indicate that, in 1975, approximately 12% of all reported cases of child abuse and neglect involved some form of sexual abuse. It is believed by many to be more widespread than the physical abuse of children, which is currently estimated to affect over 200,000 children a year in the United States. Statistics maintained over a 10-year period in Hennipen County, Minnesota (Jaffee et al., 1975), revealed 660 reports of physical abuse, and 2400 reports of child sexual abuse. Assuming that Hennipen is not atypical of other parts of the country, a picture of the possible proportions of the problem emerges. The American Humane Association has estimated that in every major U.S. city, as many as 4,000 cases of sexual abuse may occur each year (DeFrancis, 1965). Other studies indicate that some form of childhood sexual abuse may be experienced by as much as one third of the population. (Landis, 1956).

The reported incidence of sexual abuse is appropriately referred to as "the tip of the iceberg" in an area characterized by fear, denial, and reluctance on the part of family members and professionals alike to bring the problem out in the open. In recent years, the public has become increasingly aware of the plight of women victims of rape and sexual assault; it is not as well known that a large number of recipients of sexual assault are children. Although there is a higher number of reported cases among lower socioeconomic classes, as is also true with the physical abuse and neglect of children, it is not known whether this reflects the greater visibility of this group to the public social service and law enforcement systems, or whether the true incidence is actually higher among some groups. Reported incidences do show that child sexual abuse is not limited by racial, ethnic, or economic boundaries.

The most prevalent myth about child sexual abuse is the commonly held belief that its perpetrators are shadowy, raincoated strangers who haunt our parks and playgrounds in search of young victims. While it is certainly wise to warn children not to take candy or accept rides from strangers, in doing so we are alerting them to what appears to be only a small percentage of the population that actually poses a sexual threat to children. The familiar images of "perverts," "molesters," and "dirty old men" are not accurate portraits of the majority of persons responsible for the sexual abuse of children. Warnings to children might take on quite a different tone if it were more widely known that the great majority of sexual offenses against children are committed by their friends, acquaintances, and relatives. Major studies have shown that in as many as 80% of all cases, children are sexually abused by people they know and trust; parents, relatives, and parent figures are found to be responsible for up to 50% of reported cases (DeFrancis, 1969; Sgroi, 1975). These figures are especially alarming in light of the fact that intrafamily sexual abuse is even less likely to be reported than sexual assault by a stranger (Schulz, 1972).

TYPES OF SEXUAL ABUSE

Because the circumstances, reactions, and dynamics of child sexual abuse appear to differ depending on whether the perpetrator is a stranger or someone with whom the child is closely acquainted, it is useful to examine the two situations separately. In cases of assault by a stranger, the behavior of the perpetrator is more likely to be an expression of deviant or abnormal sexual preference than is that found within the family constellation, where normal or appropriate sexual preference may have become thwarted, disoriented, or inappropriately directed toward a child. Even so, most persons who sexually abuse children, whether they are strangers or known to the child, do not fit the usual nightmarish stereotype of the "child molester." Many have extremely poor self-concepts and dysfunctional personal relationships, but the majority are not considered to be "sick" as society has traditionally held (Peters, 1976; Weiner, 1964).

While aggressive sexual offenses, such as rape and sadism, do occur, they are the exception rather than the rule. The majority of cases do not involve penetration, contraction of venereal disease, or infliction of serious injury. Exhibitionism and fondling by strangers, often compulsive and habitual forms of behavior, are rarely violent and may have minimal impact on their victims, depending upon how the situation is subsequently handled. Pedophiles, those who receive their primary sexual gratification from minor children, are only a small percentage of sexual abusers. Although some pedophiles are homosexuals, the correlation in many people's minds between homosexuality and child molesters is a fallacious one that is unsubstantiated by fact. The vast majority of known child sexual abusers are heterosexual in their sexual orientation.

Sexual abuse by strangers is usually a single episode, occurs most frequently during the warm weather months, and usually takes place out of doors, in an automobile, or in a public building. In contrast, sexual abuse by family members or acquaintances is more likely to occur in the home of the victim or the perpetrator, accompanied by a host of other interpersonal and family problems, and occur repeatedly over a period of time (DeFrancis, 1969; Peters, 1976).

While there are cases of sexual abuse by adult women, the overwhelming majority of perpetrators are men. Girls are victimized or at least reported at a much higher rate than boys (the estimated ratio is 10:1), and although victims have been found to be as young as four months old, the average age is 11 years old (DeFrancis, 1969). Thus, in speaking of sexual abuse, we are primarily talking about sexual encounters between young girls and adult men with whom, more often than not, they are personally acquainted.

Since the offender is usually known and trusted by the child, incidents of sexual abuse are seldom accompanied by physical violence or extreme force. Children are accessible targets for a number of reasons. They have been conditioned to comply with authority; they are in subordinate positions and are fearful of threats; they are intensely curious; they are susceptible to bribes and the promise of reward. In addition, children are often naive with regard to social norms and values, and they are sensual beings who may respond willingly to intimate and gentle contact which they may associate with feelings of being loved, cherished, and cared for. Thus, the use of physical violence is rare because it isn't necessary: children by their very nature make ideal victims of sexual exploitation.

DYNAMICS OF THE PROBLEM

The sanctity of the home is such an established aspect of our society, traditionally and legally, that it is not difficult for a family to isolate itself from public view and public censure. Moreover, despite increased public awareness of the issue of children's rights and protection, children are still largely regarded as the property of their parents, whose right and privilege is to raise their children as they see fit. It is, therefore, extremely difficult for agents of society outside the family structure to act to deter or prevent the occurrence of intrafamily sexual abuse.

Incestuous behavior, the definition of which includes, for purposes of discussion, a wide range of child-focused sexual behavior by parent figures as well as parents and other close relatives, rarely exists as a single event. A sexual relationship between father or father-figure and child may begin innocently enough and progress from touching and caressing to fondling and overt sexual stimulation. Although most children recognize at a very early age that what is happening is "wrong," it does not always begin as an unpleasant experience for children. For some, it represents the first time they experience what they perceive to be recognition or special attention from the parent or parent figure. As is the case with some battered children, even negative, painful, or distasteful attention is better than none at all.

Despite the facade of contentment that might be maintained outside the home, incestuous families are often characterized by a high degree of family disruption and poor personal relationships. In cases of father-daughter incest it is often the relationship between the adults in the home, not the parent-child relationship, that is the key factor. The sexual relationship between the adults is often strained or nonexistent, and a great deal of underlying hostility may be present on both sides (Giarretto, 1976a). In some cases, the mother has essentially abdicated her role as wife and mother, while the daughter, in a classic role reversal situation, has increasingly taken on the adult role and responsibilities in the family. The mother, who may have experienced a cold and rejecting relationship with her own mother, may be able to avoid recapitulating this role with her daughter. There are indications that a number of these mothers were themselves sexually abused as children (Raphling et al., 1967). Thus, intrafamily sexual abuse, like the physical abuse and neglect of children, is likely to become part of a troubling cycle of dysfunctional family interactions that play themselves out in each successive generation.

The notion that incestuous fathers or stepfathers are highly sexed and aggressive men is generally false. Many are weak, resentful, and ineffectual individuals both within and outside the family; their negative self-concepts and low personal esteem make them prime targets for the adoption of behavior that is destructive to themselves and to others (Giarretto, 1976b).

Motivations for intrafamily sexual abuse and incest are often as diverse and complex as the families themselves. Although sexual gratification for the participating adults is the most obvious motive, the factors contributing to the breaking of such a strong cultural taboo as incest are rarely that simple. As previously mentioned, an unhealthy marital relationship is a prime factor in the development of resentment between husband and wife and the channeling of attention in other directions. Likewise, a daughter who sees her mother as rejecting, unjust, or dependent, may consciously or unconsciously use her father as a means of revenge. The justifications used by some men include the notion of furthering their daughter's sex education, protecting the child's physical health by preventing the contraction of venereal disease from other men, or the explanation that this is the way love and affection are expressed in their family. Incestuous fathers are often extremely conservative in their sexual beliefs and practices, and generally, do not engage in a variety of sexual practices or extramarital relationships. As one outraged father indignantly exclaimed as he was being brought to the police station. "I am a decent man. I provide for my family, I don't run around on my wife, and I've never slept with anyone except my wife and my daughters."

Family isolation, both physical and emotional, overcrowding, and alcoholism, which tends to lower impulse control, are frequently cited as antecedents to sexual abuse. Contrary to some commonly held assumptions and unlike the usual battered child syndrome, it is not uncommon for more than one child in a family to receive sexual abuse. The sexual relationship may begin with the oldest child and eventually include younger siblings as well. It is not uncommon for a girl finally to report an incestuous family situation, having discovered, after silently enduring the relationship for years to protect the siblings, that her father had been engaging the other children in the same behavior all along. Her request for protection of younger sisters often comes only after she herself has run away or grown old enough to leave home. Some girls report that their greatest sense of disillusionment came not from their father's physical behavior toward them, but from the betrayal of this type of "silent pact" to protect their siblings.

In cases of intrafamily sexual abuse, it is important to understand the role of the mother, though her role may vary greatly depending upon the individual situation. Although many women are caught in a drama that they neither see nor understand until it is publicly brought to light, this is not always the case. In some family situations, the mother's knowledge and subsequent denial of the incestuous behavior is often a key to its continuation. Sexual relationships of any kind that occur over a period of time have visible and emotional antecedents, and, in many cases, it is unlikely that a spouse could remain totally unaware of the changed personal dynamics that occur when sexual abuse or incest is present. Full sexual contact between an adult and a child within a family is invariably preceded by a long series of verbal and nonverbal expressions of growing sexual interest. The mother, in such situations, has been described as "an active nonparticipant" (Weich, 1968); her conscious attempt not to see what is happening is often motivated by her own feelings of powerlessness and horror. Whether her collusion in the incestuous relationship is conscious or unconscious, the mother's strong denial of the situation may act to provide tacit permission for the relationship to continue.

Poznanski and Bloz (1975), in their study of incest, have explained that in some families, the nonparticipating members go to great lengths to avoid acknowledgement of the presence of sexual behavior between an adult and a child. It is not uncommon, for example, to learn that a child has gone to her mother or other family member to report what is actually transpiring between her and her father, stepfather, uncle or grandfather, only to find that she is either not believed, accused of being nasty or wicked, or has caused the mother such emotional upset and anxiety that the child ends up regretting the revelation even more than the behavior itself. Many mothers in families where incest is discovered initially express outrage and denial of what has occurred, but may later admit to having known of the incest and experience a great deal of shame.

To understand the role of the mother who is aware that some form of sexual abuse is occurring in her family, it is important to recognize that her behavior is rarely motivated by the conscious desire to hurt her daughter or intentionally subject her to the sexual advances of the father or father figure. More often than not, the mother herself is a victim of her circumstances and her own poor self-image, so immobilized by a situation in which she feels powerless and ineffectual that she can take no action to protect her child. Public recognition of the sexual abuse in her family may serve to expose her inadequacies as a wife and mother. She fears the disintegration of her family and marriage, perhaps the loss of her only sources of economic and emotional support. A number of these mothers are themselves the objects of physical violence and battering at the hands of the men with whom they live. Trapped within the boundaries of their own violent relationships and often aware of the precarious and temporary nature of the protection that society is able to offer them, they are afraid to intervene actively on behalf of their children. In the dejected words of a battered mother of a sexually abused 15-year-old runaway, "I tried to give her the only things I had to offer: some money and the strength to get the hell out of here."

Fear of exposure, humilation, or personal harm all act to increase the mother's already strong dependency on the family member who is both the source of her subjugation and her protection from the outside world. Too often, in such situations, the protection of the child is sacrificed in the process of the mother's victimization.

Mothers who have been truly unaware of the sexual involvement within their families endure their own private victimization once the incest is discovered. Their initial shock may soon turn to feelings of extreme guilt over what has happened to their children. Many are plagued by self-recrimination over their inability to protect their daughters, and demean themselves for not suspecting what was going on. The realization that the victimization of a child is at least partially possible as a result of her mother's trust in the abuser is a painful one. The aftermath of such a discovery for many women involves not only their feelings of guilt, but a fundamental sense of betrayal.

In the case of child sexual assault by a stranger or person outside the family, the responsibility of the parents for the child's protection and supervision is sometimes in question. Similarly in intrafamily abuse, the role of the mother and degree of active participation by the child may vary greatly depending upon the individual situation. Nonetheless, the discussion of these various dynamics should not be interpreted to mean that it is difficult to assign ultimate responsibility when sexual intimacy occurs between an adult and a child. Although an accurate and inclusive psychological profile of the child sexual offender does not exist, the matter of accountability is not at issue. Regardless of a child's specific behavior or apparent needs, and despite any of the interpersonal dynamics which may be operating in the home, it is the adult who must exercise control (DeVine, 1977). The assignment of blame is generally not a productive approach to the problem, but the acceptance of full responsibility for his actions is usually an important aspect in the treatment of the offender. Understanding the roles of involved persons, including the victim, is important to our efforts to prevent and treat the problem, but when the violation of an adult-child relationship takes the form of sexual exploitation, the responsibility clearly rests with the adult perpetrator.

EFFECTS ON THE VICTIM

It is impossible to make a general statement about the effects of sexual abuse on children. Aside from the fact that there has been little research on the effects of sexual abuse, children react differently to different situations depending on a number of variables that may be operating at the time of the occurrence. While it is not possible to generalize across the population of abused children, this section attempts to describe some of the most serious repercussions that have been observed, and to identify a number of important variables that operate in determining a child's reaction to a sexual abuse situation.

Children who are sexually abused are not special children with special characteristics: they are not of one age, one sex, one race, or one social class. They are not victims of one particular offense, nor do they sustain identical injuries. Their role in the abusive situation, their disclosure of the incident, their relationship to the perpetrators, and their reactions, both long- and short-term, all differ (DeVine, 1977). Nonetheless, a number of key factors are commonly believed to be of critical importance in determining the ways in which a child reacts to the experience. These factors include the child's age and developmental status, the relationship of the abuser to the child, the amount of force or violence used by the abuser, the degree of shame or guilt evoked in the child for her participation, and, perhaps most importantly, the reactions of the child's parents and those professionals who become involved in the case.

It is not difficult to understand why some incidents of sexual abuse by a stranger may be far less traumatic to a child than those committed by someone close to her. In most such instances, the parents will rally to the aid of the child, and, while they may overreact to the situation, their anger and feelings of retribution are generally directed toward the perpetrator. There is less likely to be any question about possible provocation on the part of the child, who is usually the recipient of expressions of concern, protection, and support from family and friends. The degree of violence or physical coercion used by the offender is, of course, another important factor in cases of sexual assault. If a child has been raped or otherwise physically hurt by an outsider, both the short- and long-term effects can be expected to be far more serious than if, as is usually the case, the assault has been nonviolent. Many, if not most, cases of nonviolent sexual assault by a stranger can be treated with short-term crisis intervention techniques that emphasize putting the incident in perspective and returning the family to its former state of equilibrium.

Intrafamily sexual abuse, including that initiated by persons whom the child or other family members hold in high esteem, usually has far more complicated temporary and long-term repercussions. It is believed that the closer the emotional ties between the child and the perpetrator the more emotionally traumatic the situation is likely to be for the child (Sgroi, 1975); nonetheless, the degree of emotional impact will vary greatly depending on the nature of the individual relationship.

The child's role or the manner in which she perceives her role—in the sexual relationship can have a strong influence on the way she reacts to the situation once it has been disclosed. Very young children often have difficulty separating fact from fantasy and may have a very different and less distressing image of what occurred than others in the family have. Their view of the world may provide a layer of unconscious self-protection that enables them to react only to what it is they imagine has happened to them. However, this type of initial reaction may be quickly colored by the more violent reactions of the adults around them.

If the sexual behavior between adult and child has occurred over a long period of time, if it has involved a series of progressively intimate incidents, or if the child is old enough to understand the meaning and cultural taboo of what has occurred, then the effects may be more profound. Extreme feelings of guilt are a common consequence of intrafamily sexual abuse and cause many victims a great deal of anguish. Guilt feelings may be intensified by a number of factors, including the degree to which the child actively participated in or encouraged the sexual contact, and whether she herself experienced pleasure when it happened. Regardless of whether her pleasure stemmed from the accompanying feelings of acceptance and adult approval or from a normal physical reaction to sexual stimulation, the acknowledgement of some level of enjoyment is a painful source of shame for many children. With children for whom the experience was totally repugnant and upsetting, guilt may stem from the fact that they allowed the situation to continue because they felt too fearful and powerless to take any action to stop it. Such guilt is particularly poignant if a child believes that her passive acceptance of the situation resulted in the subsequent abuse of her siblings.

The reactions of a child's family can do much to either lessen or enhance her guilt feelings following disclosure of the abuse. DeFrancis (1969) has described initial parental reactions as either child-oriented, self-oriented, or offender-oriented. The object of a family's blame or support in such situations is dependent upon a number of variables. The degree of public humiliation experienced by family members and their concern for what other people will think may undermine any support for the child's position. As with many personally traumatic experiences, the need to blame somebody for what has happened is sometimes a strong one. The mother may put complete blame on the offender, or she may blame herself for failing to protect the child adequately. While both reactions may be normal ones under the circumstances, unless they are accompanied by a focus and concern for what the child is undergoing, they may not be constructive reactions.

As mentioned earlier, the benefits of supporting the child may be outweighed by the very concrete losses that the family might experience if the father or family provider is put in jail or ordered to keep away from the home. In such cases, the family's anger and frustration may be focused on the victim who may find herself being blamed for initiating and perpetrating the sexual relationship or for breaking up the family by revealing the situation, or both. This form of "blaming the victim" can have a devastating impact on a child who is usually already guilt-ridden from the blame she has imposed on herself.

Even if a child has not experienced extreme guilt or confusion as a result of the sexual contact itself, she is often likely to discover it once she comes into contact with the so-called "helping system." Due to the seriousness of the crime of sexual assault, such accusations are often viewed with a great deal of suspicion. Again, as has been the experience of many rape victims, the child victim may find that it is her own credibility which is in doubt, and her strongest emotional reactions may occur as a result of this recrimination. Even when a very young child has incurred physical damage as a result of sexual assault, her reliability may be questioned, as in a case cited by Walters (1975) of a four-year-old girl who was hospitalized with massive internal injuries, and was asked by an emergency room nurse, "Were you playing with yourself?"

In cases where the sexual contact itself was not immediately traumatizing to a child, the ensuing separation of a child from her family may be the event that carries the most severe or lasting emotional impact of all. Feelings of grief mixed with guilt over the loss of a special person or relationship, regardless of the pathology involved, may be the effect felt most strongly by the victim.

Behavioral indicators of the effects of either the abuse or its disclosure can take many different forms. Some children manifest their reactions by regressing to earlier types of behavior such as thumb sucking, bed wetting, or becoming afraid of the dark or certain locations which have negative associations for them. Others develop a variety of behavioral disorders such as sleepwalking or difficulty in eating and sleeping. Such physical symptoms may constitute the child's way of acting out those disturbing feelings and reactions that she is unable to verbalize.

Even less is known about the long-term effects of sexual abuse than about the short-term reactions. Sexual abuse has been referred to as a "psychological time bomb" because of the dormant nature of some of its aftereffects, many of which may not be realized until the child is old enough to establish adult sexual relationships of her own. It is then that she may discover her inability to disassociate the sexual aspects of that relationship from her negative experiences as a child. It is believed by some that the low self-esteem and self-interest of many victims leads them to engage in a variety of self-destructive behaviors. Girls who react by turning their self-hate inward may be likely to become involved in drug or alcohol abuse. In studies of female drug abusers, as many as 44% of them had been sexually abused as children. (Benward and Densen-Gerber, 1976). Similarly, some girls display their internalized feelings through outward displays of self-abuse as adolescent promiscuity or prostitution. James (1971); in her study of prostitutes, found that approximately 30% of them had been sexually exploited during childhood. For some, the exploitation of their own sexuality may become the only way they know to relate to others.

A number of girls appear to jump into early marriages as a means of escaping their family situations, or dealing with their feelings of aloneness. Many experience a sense of isolation when they realize that they do not have any peers who could understand what they are going through. Depression and confusion about their own identities are not uncommon reactions of many victims. Some report feeling "marked" or stigmatized for life and may have suicidal tendencies. Others, with support and understanding, may be able to comprehend their roles as child victims within the perspective of adult responsibility for what occurred, and thus may not suffer lasting consequences of the abuse.

No two children or families will react in exactly the same way to the presence of child sexual abuse. Also, because they are under a great deal of stress, their reactions and behavioral signs, whether conscious or unconscious, are subject to misinterpretation. Generalizations about the effects of any kind of interpersonal crisis often do a disservice to all the individuals involved. Children, no less than adults, need interpreters in society who can hear the unique story that each has to tell.

VICTIMS OF THE SYSTEM

Although society reacts with predictable horror at what is done to children by sex offenders, it apparently does not share a similar concern for what often happens to them subsequently at the hands of our law enforcement and child protection systems. Whether a child has been sexually assaulted by a stranger, an acquaintance, or a member of her own family, when the incident is brought to light the family is usually found to be undergoing a state of crisis as it works through feelings of anger, fear, shock, and confusion. In the midst of such vulnerability, the criminal justice, health, and social service systems may descend upon a child and family with such a devastating impact that its recipients are left with the feeling that the "cure" is far worse than the symptoms. Many authorities agree that the emotional damage resulting from the intervention of "helping agents" in our society may equal or far exceed the harm caused by the abusive incident itself. (DeFrancis, 1969; Giarretto, 1976b; Minar, 1966; McKerrow, 1973; Sgroi, forthcoming).

More parents and professionals might be willing to report suspected cases of sexual abuse if they could be confident that the effect of their actions would not be to appreciably add to the trauma the children already were experiencing. It is an assurance that few communities are able to make. Once a case of known or suspected sexual abuse is reported, a series of investigative, protective, and prosecutorial procedures spring into action. Although the specific steps vary, depending upon state law and procedures, whether the report is made to the police or to the department of social services, and whether the case is handled under civil or criminal statutes, it can be a complicated and overwhelming process for those involved.

The child, who is usually under a great deal of emotional stress already, may be required to recount the details of the case over and over at various stages in the legal process. If the situation is reported to the police, as is required by law in several states, she may have to tell her story first to a patrol officer during the preliminary investigation, and later to a police detective neither of whom may have had any specialized training dealing with a child witness. When child protective services are involved, a separate investigation may be initiated, which involves an interview with at least one social worker.

During the process of investigation, the child may be taken to a hospital or private physician for a medical examination. Here, again, the child is usually expected to recount the incident or incidents leading to the report. Concerned physicians, such as

Sgroi, have pointed out that a thorough and gentle examination can serve to calm and reassure a child that she is physically all right (Sgroi, forthcoming). However, as many women and most rape victims attest, a gynecological exam, even when performed under the best of circumstances, can be an upsetting experience. This may be true especially if the girl is very young, if it is the first time she has undergone such an examination, if the physician is a male and a stranger to her, or if physical restraints or strong words of admonition are used to calm her. The situation can be exacerbated if the medical personnel are not trained or sensitive or willing to spend the time and patience required to handle these disturbing cases.

If the case is to be handled under criminal statutes, it will most likely be referred to the Prosecuting or District Attorney's office, where the girl will again be interviewed, sometimes more than once, in order to evaluate the force of the evidence, the victim's credibility as a witness, and the strength of the case in general. Even if there is a decision not to press criminal charges, the case may go to civil or juvenile court to determine such matters as child custody and supervision. In this case, the child may be interviewed still another time by the court attorney, city solicitor, or guardian ad litum appointed by the court to represent the best interests of the child. In the end, it is not unusual for a child to have to repeat her story six or seven times or more, even if the case never goes to court.

Although many children are spared the agonizing ordeal of a full trial since such cases are often resolved by plea bargaining and dropped charges, a criminal case may quickly develop into an adversary proceeding between child and adult. In cases where preliminary hearings are held to determine whether the accused should be bound over for trial in Superior Court, the child must confront her assailant (possibly for the first time since the assualt or since the report was made, even if the assailant is her father) in a courtroom situation. Once again, she must recount the exact details of the abusive situation, and her testimony is subject to cross-examination.

The differential and complex way in which our society treats children who come into the criminal justice system is a subject of considerable relevance for the victims of sexual abuse. Although the United States was the first society in the world to establish a separate justice system for its juveniles, that system was not signed to protect *all* children who must undergo criminal proceedings, only those accused of committing criminal offenses. Our juvenile courts were established on the belief that the special needs, vulnerabilities, and limited experience of children make them significantly different from adults; thus they warrant a court system that is sensitive to those differences. Presumably, a young child who is either a victim or a witness to a crime committed by an adult is in need of at least as much special consideration as a juvenile offender. Unfortunately, in the criminal court there may be little allowance made for the child victim's limited ability to comprehend and compete with her adult counterparts (Stevens and Berlinger, 1976).

Testifying at an open trial is a stressful experience for even the most secure adult, and is often the most difficult encounter of all for the child victim of sexual abuse. The child may have to sit alone on the witness stand answering a series of complex questions and pointing out the accused in a courtroom filled with spectators. This author will never forget the look on the face of a 9-year-old incest victim when her father was brought into the courtroom with chains and handcuffs around his hands and waist. With support and reassurance from concerned professionals and family members, she had, up until that point, coped remarkably well with the rigors of the judicial process. Her only comment before she withdrew into a spasmodic, twitching episode (which recessed the trial for the day) was, "I did that to my Daddy."

Regardless of a child's age, she is usually not protected from the Defense Attorney's attempts to attack her credibility on the witness stand. As have many adult rape victims, children who have been sexually abused, some of them as young as 7 or 8 years old, may quickly find that their own personal lives and behavior appear to be on trial. Often judges and prosecutors are reluctant to intervene for fear of appearing too protective or of swaying the jury. The child is often expected to provide information on dates, times, and sequences, plus a detailed description of the abusive situation and events that preceded and followed it. Her story is often regarded with a great deal of suspicion, and a number of concrete external proofs of abuse, such as witnesses, physical injury to the child, presence of semen or penetration, must usually be present. It often seems that society's primary interest in the child is in the testimony she can give for the conviction of her abuser. The entire process has the effect of abandoning the child to a set of abstract principles of justice (Stevens and Berlinger, 1976).

Even when a child is not directly involved in a criminal court proceeding, the only methods available in most communities for dealing with intrafamily sexual abuse involve the forcible, or sometimes voluntary, separation of perpetrator and victim. Giarretto (1976a) has pointed out that, with rare exceptions, the repertoire of law enforcement, judicial, and social service personnel handling child sexual abuse cases is limited to two devices—separation and punishment. In cases where the burden of reporting or testifying lies primarily with the mother, she is put in the position of having to decide who will go, her husband or her child. Either way, there are often serious repercussions for the child. If charges are pressed, and the father or father figure goes to jail, the girl will often see herself as responsible for breaking up the family. If she is taken out of the home to be placed in a foster home, she may internalize her removal as evidence of her own innate badness and guilt. This perceived assignment of legal guilt not only serves to allow other family members to maintain a destructive denial of their own responsibility, but, as is so often the case, the girl may, in her foster home, act out her feelings of shame, guilt, and confusion to the point where she has to be placed in another home. This drama may be re-enacted in a series of foster homes and institutional placements until the child has convinced herself, if not those around her as well, that she is a thoroughly unlovable and destructive individual.

Although society has traditionally looked to the machinery of the criminal justice and protective service systems to provide the best available assistance to victims of sexual abuse and their families, the process has often meant additional traumatization for *all* persons concerned. There are pitifully few treatment programs available to the perpetrators of sexual abuse, prison sentences are usually not of long duration, and offenders, if they do go to jail, receive few if any rehabilitative services. Convicted sexual offenders find when they reach prison that, even in a society of criminals, they occupy a pariah status and are in physical and sexual danger from the other inmates (McCaghy, 1971). They quickly become the victims of another kind of system, where they find themselves holding the most despised status on the reordered social scale.

In situations where there is already a high degree of family disruption, the threat of forced family dismemberment may take on much greater significance to family members than anything that has previously happened to the child. The legal process may act to entangle the entire family in a web of retribution. There are few sights more disturbing than watching a mother transfer her support and allegiance from her young daughter to her husband or lover as they progress through the justice system. The child may be left with no functioning adult ally in the household once her sacrifice is seen as a way of salvaging the adult relationship; she is left alone in the role of accuser. Such cases should not be taken to criminal court unless a conviction is assured. There are indications that, in the absence of any continued protection from the mother or other adult family members, a child who is put on the witness stand to publicly accuse her father of incestuous behavior may be in grave physical danger if he is subsequently aquitted and allowed to return home.

Perhaps the most telling indictment of our present system of child protection is contained in an interesting theory regarding one way to determine the difference between a report of actual intrafamily sexual abuse and one fantasized by the child. It is believed by some that, in the case of true sexual involvement between a child and another family member, the child will often be back in a week or two to deny all of her charges and retract the report. This happens, it is hypothesized, because the societal intervention that has occurred during the ensuing days or weeks has proven to be even less tolerable and more upsetting to the girl than the previously existing situation. The abused child came seeking protection and an end to the abuse, not an end to her family. The girl who falsely accuses a family member, on the other hand, may be more likely to stick by her story because society has given her exactly what she wanted: retaliation and total family disruption.

Although more and more communities are developing specialized child-centered services for the victims of sexual abuse, we have a long way to go. It is not surprising that perhaps the most frequently chosen solution is for the child, as soon as she is old enough, to rebel and leave home. It is, unfortunately, the case that, for many children and their families, society, no matter how well intentioned, is the cruelest assailant of all.

PRESCRIPTIONS FOR CHANGE

Perhaps the most important thing to keep in mind, for those who seek to help children and families who are the victims of sexual abuse, is contained in an ancient expression familiar to the medical profession: *primum non nocere;* first, do not harm. We are often helpless to prevent or undo the negative interactions that occur between adults and children: we *can* do something about what happens to a child following disclosure of the incident. It is important to remember that sexual abuse in its various forms does not *automatically* leave permanent emotional scars on its victims. This is said with no intent to minimize the negative effects of sexual exploitation, but with the belief that children need the adult world to respond appropriately to their individual needs and circumstances. By reacting out of our own needs for retribution or immediate resolution of a repugnant situation, we can, and repeatedly do, make life worse for the children involved.

The first step toward insuring that we don't compound an already stressful situation is to consider the effects on the children involved of every ameliorative action contemplated. While any major disruption in a child's life is bound to cause anxiety and fear, especially if it threatens his or her basic family structure, constant maintenance of a child-centered orientation at each step of the process can go a long way toward reducing the stress. A child's world revolves around the family, and no matter how dysfunctional that family may be, it is usually the only one she has ever known. Most maltreated children want the abuse to end, not their families to end. It is difficult for most children to accept the fact that it could be their parents, not they, who are wrong or who have behaved badly. Understandably enough, this is especially true if the child is taken out of the family. In their young minds, parents are parents, and it is children who are bad and get punished. The author once worked in an institution largely populated by children who had experienced the most extreme forms of physical, sexual, and emotional abuse at the hands of their parents. These children had very diverse backgrounds and had coped with their experiences with varying levels of emotional adjustment; but they all had one thing in common—they all wanted to go back home to their families. They would insistently promise that, if allowed to return home, they would be careful not to provoke their parents to hurt them, abandon them, or sexually misuse them again.

It is important to keep the perceptions of children constantly in front of us, not because it is always possible to keep from compounding their private pain, but so that we always strive to provide "the least detrimental alternative to the child" (Goldstein, Freud and Solnit, 1973). We cannot always avoid splitting up families or placing a child in a foster home when there is no other way to protect her from further abuse, but such action should be a resource of last resort, not an attempt to appease our initial feelings of horror. Although society is not, for a variety of reasons, presently able to tolerate the possibility of recurrence of intrafamily sexual abuse, the time has come to question whether the immediate removal of a child from her own home, or her participation in the arduous process of a court trial, is ultimately in her best interests. There have been cases of long-standing sexual involvement in the home where children have been forcibly removed by the police within an hour following disclosure of the situation. A child may find that, in the space of one afternoon, she is living with strangers, prohibited from seeing her parents, and in a new school district away from friends as well.

It should also be remembered that many children have a distorted sense of time; a few days can seem an eternity to a young child. When we speak of temporary foster care, we would do well to bear that in mind. Many "temporary" foster and institutional placements of children stretch on into years of separation, until the child has virtually no family as she knew it to return to. Children have the right to a home in which they can be assured of permanence; if we judge their own to be inadequate and are unsuccessful in an intensive attempt to rehabilitate it, then we at least owe them permanence in another setting.

In most cases of sexual abuse, as with many other family problems that threaten the well—being of children, if we really want to help the child we will first do our best to help save the family. Again, it is not always possible, but far more could be done than is presently being attempted. There are few sexual abuse treatment programs associated with the prisons in this country. There are even fewer programs that attempt to involve the whole family in treatment. The Santa Clara County Child Sexual Abuse Treatment Program in San Jose, California, is the only program in the country specifically developed to treat incestuous families.

Treatment programs are obviously only one aspect of our system for dealing with child sexual abuse which needs improvement. Attention must be focused on the needs of children and families from the time that a situation is discovered. Special units or teams of professionals in hospitals, police departments, and social service agencies should be trained to deal with sexual abuse and to become sensitive in their interactions with children. Whenever possible, cases should be handled by social workers or at least plainclothes policewomen, since children are often frightened by police officers in uniform.

In our desire to protect children from distressing situations, we cannot ignore the reality of many existing legal and medical procedures. Criminal laws that involve the child witness will not be disposed of simply because they make therapeutic intervention difficult. They must be changed where they are destructive or insensitive to their effects on children, and, where families are involved, they must be humanistically refocused on rebuilding rather than destroying family units. Children should undergo a minimum of interviews about what happened; if ten professionals must hear the story, let it be recorded on tape the first time around. Medical examinations of young girls should be conducted only when necessary and by female physicians or a family doctor known to the child. They should be performed with the utmost sensitivity and care. Every attempt should be made to handle court cases in pretrial conferences, judges chambers, or special settings adapted to use by children and not open to the public. Child victims should, at a minimum, be entitled to the same considerations and special provisions as child offenders. In addition, they require careful treatment and follow-up to determine what long-term effects the abuse may have. It is not enough to remove a child or other family member to another setting and call it treatment, though our present system often functions as if it were. Whether children are abused by strangers or by someone they know well, they need to be treated with compassion and understanding; we must stop treating them merely as evidence. The procedures and requirements of our judicial and protective systems make it difficult not to add to the trauma child victims experience. But we should at least be able to promise that the "help" we provide will not leave them preferring the previous sexual abuse to the abuse imposed by an insensitive system.

CONCLUSION

Our knowledge about the sexual abuse of children appears to be evolving in a pattern similar to that of knowledge about the problems of battered women, battered children, and rape victims. This pattern begins with the disturbing discovery that the prevalence of the problem and the number of extreme situations are much greater than previously imagined. Then a concerted effort to gather more information typically reveals an insidious, secondary level of abuse; i.e., the way victims are treated by society and its institutions following disclosure of the abuse. It is not until the scope and ramifications of the problem are fully realized that we see improvement in the lot of victims and the restructuring of social institutions.

Another important aspect of child sexual abuse has to do with prevention and how we raise our children. Little girls learn at a very early age how to be provocative and coy. They are surreptitiously encouraged by the myriad of material things that surround them—their toys, the television, and what they read. Parents and friends knowingly and unknowingly encourage them to grow up fast, to use their wiles to their advantage. Their sexiness may be reinforced before they are old enough to understand what it means. When sexuality in young children is encouraged, they become confused as to its appropriate purpose and function. The very behavior and dress they use to get adult attention and approval may make them vulnerable to kinds of sexual exploitation they are not emotionally or developmentally able to manage.

Similarly, young boys are often raised with inappropriate expectations about sexuality and women in general. The notion that sexual pleasure may be taken, either by physical force or coercion, or that women and children "ask for" sexual exploitation by their behavior or vulnerable status, is one which is all too often subtly reinforced in our society. As long as prevailing societal attitudes reflect a view of women as sexual objects, and as long as the rights of children receive such casual regard, female children may remain an especially vulnerable target for sexual abuse. True confrontation of a problem as insidious yet as pervasive as child sexual abuse ultimately requires the type of primary prevention which seeks to change the contributing attitudes and behaviors found in our society. Thus, one aspect of preventing child sexual abuse involves the projection of images and values onto children. Children must not grow up with the kind of expectations and attitudes which will allow them to objectify others to the point of exploitation; at the same time, they must have help in insuring that they do not covertly appear to be eliciting sexual behavior with which they cannot cope. Another aspect of prevention is to adequately prepare and protect children from inadvertently becoming trapped in the role of victim. One way to do that is to provide them with more education about the nature and indicators of sexual abuse and what to do if they experience it. The fear, of course, is that in so doing we will make our children paranoid or unduly distrustful of the people they know and of any intimate or affectionate behavior. The fear is a legitimate one, but is most likely outweighed by the potential of such an educative process, if sensitively handled, in providing a child with the kind of psychological armor he or she might need to successfully prevent exploitation. We may tell our children not to talk to strangers, but we often neglect to tell them why, so that if and when they are subjected to sexual abuse they are unsure of what is happening and what to do about it. If they can be taught the differences between appropriate and inappropriate adult-child physical interaction (regardless of who the adult may be) they are in a better position to prevent or at least seek help for their own victimization. As one former sexually abused child so pointedly put it, "They told me never to accept rides or candy from strangers, so I never did. They never told me to watch out for my own father or why."

Our challenge is to prepare children for any eventuality of sexual exploitation without scaring them to death. We must counterbalance their natural passivity and deference to authority by providing them with a strong sense of what other people should and should not be permitted to do to them under any circumstances. They must know that they will be supported in their efforts to act and speak out against being victimized. If, for whatever reason, they are not being protected within their own homes, they need to know that there are other supportive avenues of help available. In that regard, school personnel and other adults who have contact with children must be alert to the visual signs and halting messages of children in trouble. Child victims of sexual abuse can only be as strong and effective in acting on their own behalf as the protective system and the adults who are standing behind them.

Sexual abuse of children has existed for centuries, though it has only recently come into the light of public attention. Even when the problem is recognized, it is often compounded by our clumsy and ineffectual attempts at immediate solutions. Except in a minority of cases, the problem can not be effectively dealt with simply by invoking the retribution of our criminal justice system. Our desire for retaliation may provide a consoling outlet for our initial feelings of outrage, but it rarely solves the underlying issues. Children need education about sexual abuse and sexuality in general. They need a sense of themselves that will help to insulate and protect them against victimization and victim mentality. Parents need to be helped to handle their own sexual feelings appropriately, and protect their children from the exploitation of others. Professionals need training to help them recognize the symptoms of sexual abuse, and the criminal and protective service systems need to be changed so that they deal fairly and humanely with the problem.

A cause for optimism lies in the fact that the process of identification, assessment, and resource development has begun in other problem areas similar to that of child sexual abuse. In rape cases, the past five years have seen the incidence of reporting rise, judicial impediments modified, and public attitudes slowly change. Certainly much remains to be done for the victims who learn daily that what society offers is insufficient to meet the need. All victims of our society's cult of violence and self-gratification deserve our compassion, our energies, and our voices for change, but none more than our children, who have no voices of their own.

NOTE

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GUIDELINES FOR INTERVIEWING CHILDREN

DO:

- Make sure the interviewer is someone the child trusts.
- Conduct the interview in private.
- Sit next to the child, not across a table or desk.
- Ask the child to clarify words/terms which are not understood.
- Tell the child if any future action will be required.

DON'T:

- Allow the child to feel "in trouble" or "at fault."
- Disparage or criticize the child's choice of words or language.
- Suggest answers to the child.
- Probe or press for answers the child is unwilling to give.
- Display shock or disapproval of parents, child, or the situation.
- Force the child to remove clothing.
- Conduct the interview with a group of interviewers
- Leave the child alone with a stranger (e.g., a CPS worker).

PROGRAM TITLE: *MEDICAL INDICATORS OF CHILD ABUSE AND NEGLECT PART 5: SEXUAL ABUSE*
SOUND FILMSTRIP
15 MINUTES—71 FRAMES

MEDICAL INDICATORS PART 5: SEXUAL ABUSE

	1. Focus frame: BEGIN SOUND HERE
	2. Curriculum Title: "We Can Help . . ."
	3. Title: PRODUCED BY URSA
	4. Unit Title: SPECIALIZED TRAINING FOR MEDICAL AND HEALTH PROFESSIONALS—UNIT 14
	5. Program Title: MEDICAL INDICATORS OF CHILD ABUSE AND NEGLECT PART 5: SEXUAL ABUSE Supered over on right or bottom of slide of girl sitting in waiting room, pensive.
NARRATOR: The child who is a victim of sexual abuse often bears no physical marks.	**6. Girl's face, pensive.**
But the emotional scars may last a lifetime.	**7. Girl's face, hands over, frightened.**
The examination of the sexually abused child requires special attention and concern on the part of medical professionals.	**8. Girl with doctor or nurse on bench, doctor has arm around her, girl still, with hands over face, hunched over.**
NARRATOR: Dr. Raylene DeVine, a pediatrician on a team at the Child Protection Center, Children's Hospital, Washington, D.C., has been involved with the special problems in dealing with and diagnosing the sexually abused child.	**9. Dr. DeVine in office.**
DEVINE: The most frequent reason we examine the child for sexual assault is because the child has confided in someone. This person is not always the parent but frequently a guardian, or a counselor at school, or a	**10. Girl confiding with friend.**

grandmother or someone the child feels comfortable with.

NARRATOR: Many times a child will tell about an assault a long time after it happened. If the assailant is close to the child, as in cases of incest, it may take a longer time, even years, before the child will confide in someone.

DEVINE: Sometimes we have an observer, another playmate, someone who walks in and catches the child in the compromising situation.

NARRATOR: Though they might not know exactly what happened, they have observed enough to suspect sexual abuse.

DEVINE: Less frequently the child will have some kind of physical injury such as bleeding, or a discharge, some itching, some pain, and when asked why they are bleeding the child may not say anything but the parent is suspicious enough to bring the child in for an examination.

NARRATOR: Sometimes the child has venereal disease and the parent has no idea where it came from. The parent will bring the child in because the child has a vaginal discharge.

DEVINE: Very infrequently the child is brought by the police because the child has been beaten and raped and has been found like that. That is a very small minority of the sexually abused children.

NARRATOR: Because of society's attitudes towards sexual abuse, the physical exam for the parents, the child and the physician is an emotionally charged and therefore delicate situation.

DEVINE: I emphasize that a lot of emotional trauma can be minimized by changing the way we react to the child's complaint of sexual assault.

NARRATOR: It is important for the physician to be careful not to make the examination more traumatic than the assault itself.

DEVINE: What I try to do when the child comes in, first of all, I never leave the child alone, but do interview the parents and the child separate . . .

DEVINE: . . . so when the child is being left alone, and separated from the parent, I try to find someone the child can establish a trust in.

NARRATOR: The history of the assault is often confusing. The parents may not be sure what happened. However, the physician can get a general feeling for the things the child is going through at the time, his development in school, his behavior with friends and at home. This may help to determine if sexual abuse has been going on for a while.

11. Girl alone, staring out window, book open on lap—daydreaming.

12. Adult, peeking in a door.

13. Young (9-10-year-old) girl looking uncomfortable. Talking.

14. Mother and girl entering hospital.

15. Newspaper headline which reads "CHILD ASSAULTED." Hand on pages, holding it up, as if reading.

16. Family: Young boy, mother and father in hospital corridor, distraught and anxious, LS—family seen as isolated.

17. Close-up boy's face.

18. Doctor meeting boy and family.

19. Parents seated in waiting room (shot over their shoulders or past them), doctor, arm on child's shoulder, or hand in hand going away, down corridor.

20. Doctor introducing nurse to child, nurse has books or crayons with her.

21. Doctor talking with parents in his office, parents worried, doctor concerned.

To minimize trauma, if at all possible, the child should only be interviewed *once* by one person. A series of interviews is often upsetting. Interviewing the child presents other problems . . .	**22. Doctor with young boy interviewing him in office.**
DEVINE: Probably the biggest problem we have in interviewing the child is vocabulary. It's like talking another language. The child's words for vagina or penis are maybe entirely different from medical terms, and until we know what words the child uses for those things, we cannot take a history.	**23. Close-up pensive face of boy.**
Sometimes I use dolls. Nonthreatening type of rag dolls with a fake kind of penis and vagina and ask the child what this is called and what that is called and then I can interview them on their level.	**24. DeVine with dolls on sofa, or child with dolls.**
NARRATOR: The age of a child can make a difference too.	**25. DeVine at her desk looking at someone arriving in office.**
DEVINE: The older children have particular fears, sometimes they are irrational and sometimes they are totally unpredictable . . . you must be frank, but try not to give them too much information . . . we introduce fears in their mind that they actually didn't know could possibly exist.	
Prior to the physical examination of the child, the doctor should have everything he may need at his fingertips. Even the forms that are necessary and the medical/legal form from the police should be available before he begins examination.	**26. Forms and swabs etc., ready on exam table.**
Each step of the examination should be explained to the child . . . we anticipate what we are going to do by the history.	**27. Girl on exam table, female doctor holding up picture of vagina, demonstrating with swabs what she will do. (Over girl's shoulder.)**
We look where the child gives us an indication where we should look, we do not indiscriminantly culture every anal/genital oriface because the medical/legal form says those things should be cultured. We only culture what is necessary.	**28. Girl responding, explaining, (over doctor's shoulder).**
I do not feel that a child should be examined forcefully . . . . . I feel strongly that most children are comfortable with a person of their own sex after sexual trauma . . .	**29. Split screen: Male doctor and younger boy, female doctor and girl, both instances, child and doctor in examination room.**
NARRATOR: The examination procedure and the physical indicators of sexual abuse vary according to sex and age.	**30. Two circles: Moody portraits of young boy and girl from previous frames.**
DEVINE: The things we are looking for in most female children is some change in the genitalia . . . that would show us that some kind of assault has occurred . . . this might be redness, erazema, some bleeding, some abrasions, some edema . . .	**31. Medical illustration: Front view vaginal area.**
The things that are often overlooked and are many times helpful is the size of the introitus. The size of the introitus changes as the child grows, but obviously if the child has been subjected to repeated sexual penetration that introitus will be enlarged.	**32. Medical illustration: Front view of introitus, enlarged.**

We try to visualize the hymen, but the presence or absence of the hymen has nothing to do with whether the child has been assaulted or not, unless we see fresh tears and bleeding in the hymen.

Most of those things can be seen by the physician using his hands . . . the child's legs are nicely apart and the physician separates the labia and pulls down at the same time on the perineum, very carefully and gently.

Very seldom do we need to use a nasal speculum. Very, very seldom do we need to use a vaginal speculum. Those things should be used if there is bleeding and source of bleeding cannot be seen.

NARRATOR: Attention may also be focused on the anal and oral areas in children, looking for the same types of findings as in the vaginal area, according to the history given by the child.

In the cases of teenage girls a pregnancy test may be pertinent for medical/legal purposes and if there is a chance of pregnancy the physician should let her and her family know about the availability of pregnancy preventative drugs and their complications.

DEVINE: With most of our boys it is a little easier to examine because if it is an injury to the penis it's very easy to see.

Many times a boy's complaint is a sodomy complaint and therefore, we center our attention on the anal area. Oral sodomy may be a more common complaint with boys.

NARRATOR: For both male and female children, the use of sedation and general anesthesia should depend on the severity of the injury, repairs required and the emotional state of the child.

Lab tests for both male and female children generally include a swab for sperm, or a smear for motile sperm, or a culture or smear for gonorrhea.

DEVINE: Those tests will be done in the area on which the child's complaint centers. They can be done all at once. We use moist cotton swabs, never dry, and we can take three swabs at one time. The swabs should be shown to the child first. The child should know what is going to happen.

NARRATOR: The VDRL is often done at the time the child comes into the hospital for medical/legal purposes, to verify that the child did not have syphilis prior to the assault. Then it is important for the child to have the VDRL again anytime up to three months later.

As sexual assault is a criminal offence in most areas, evidence found by the physician during the physical exam is often used in the court procedures.

It can be crucial that these lab tests are handled carefully.

DEVINE: Frequently they cannot be used for evidence unless they are taken by the physician or nurse directly to the laboratory and are signed for by the person in the lab as accepted and as evidence from this particular patient.

NARRATOR: Other evidence may include blood or sperm on the clothing. The physician may take the

33. Medical Illustration: Side view, internal vaginal cavity with hymen intact and dotted lines.

34. Medical Illustration: External, CU vaginal area, with hands separating labia, thumb pulling down on perineum.

35. Photo of speculum in dish.

36. Woman doctor doing throat culture of girl.

37. Portrait, teenage girl.

38. Medical photo: Bruised penis.

39. Medical Photo: Traumatized anus.

40. Girl, pensive face.

41. Doctor holding petrie dish, smearing with swab, making culture.

42. Female doctor showing girl swabs, demonstrate holding three swabs at one time.

43. CU: Arm of girl ready and held by doctor for blood test.

44. Doctor filling out forms, with lab test in front of him.

45. Nurse handing forms and tests to lab technician, or in lab, technician looking over forms and tests.

46. Dirty or damaged underwear in plastic bag

damaged clothing, place it in a bag and label it, or photograph it. If pubic hairs are present, you may want to comb or clip them as possible evidence too.

NARRATOR: Most areas have a legal form which the physician must fill out indicating the results of the examination.

DEVINE: Most often it's the same form that they use for adults, and many times does not have a place to write down the subtle findings that you find in these children.

NARRATOR: When filling out the forms, the physician may be hesitant to interpret his findings and to get involved in the legal process. All he has to do is present his evidence. He is not bound to draw conclusions from these findings.

DEVINE: The doctor, I think, can be a help to the child if the child has to testify in court. If the doctor feels that his rapport with the child is not that good, he may want to give the job to a social worker. But the child through the legal process should be supported.

NARRATOR: Follow-up procedures include the re-examination of the child.

DEVINE: The medical appointments that must be done for medical reasons consist of the initial examination, the 48 hour follow-up, the 4–5 week follow-up and then 3–4 months follow-up.

NARRATOR: In any case of sexual abuse, the parents and the child usually have a great deal of anxieties or fears. Follow-up and counseling are important. What is possible depends on the particular family and the nature of the assault.

DEVINE: Children who have suffered incest differ from children who have suffered sexual assault from the babysitter, or a neighbor or a stranger. These children have to deal with a family pathology that is deeper, that has been going on many times, for a long time, and we will expect a greater emotional damage from the actual experience of incest.

In cases of incest many times we find a more hostile reaction to the people involved in interviewing the child and trying to determine if this has happened because of this denial; instead of asking for help many times they say they don't want help.

NARRATOR: But no matter what the situation, help should be extended to the parents as well as the child. Parents whose child has suffered an assault by some other person need support.

DEVINE: You must deal with a lot of anxieties, fear, and emotional reaction that the parents have to this assault. They come into the hospital usually in fear and anger . . .

. . . the father frequently is just furious at whoever has done this to his daughter or son and is going to go out and administer justice himself.

DEVINE: The mother is frequently torn between two responses, one is a guilty response: How could this

with label, doctor filling it out.

47. Close-up medical/legal forms.

48. Male doctor filling out forms, looking concerned, may be looking off, thinking of what he is writing.

49. Male doctor, in civilian suit, going up stairs of official court building or on phone, concerned.

50. Male doctor and boy in exam room, talking—doctor with forms, boy on exam table: burn in times over photo.

51. MS: Over parents' heads and shoulders, boy's face looking at them anxiously.

52. Evocative photo, dark profile of father, girl looking at him, frightened or eyes cast down.

53. Dark profile, head turned to girl turned away, hand to face as if a blow is expected.

54. MS: Over boy's head and shoulders, faces of parents—anxious, angry, fearful.

55. Closer in—faces of parents.

56. Close-up on man's clenched fist.

57. Mother—hand over face.

happen to me? I've been a good mother. How could this happen to me? And the other one is her concern for her child.

But you must constantly remind them that their primary concern is for the child.

NARRATOR: Concern and protection for the child can be overdone. The parents may prevent the child from going to school, or playing with friends. The child should be encouraged to return to her normal way of life.

We should also let the family know some ways the child may behave, before it happens, such as sexual acting-out with dolls or sexual experimentation with friends.

The parents should be careful not to overreact.

DEVINE: If we're not too upset, the child will not be too upset, if we handle the experience, the child will forget that experience . . . or put it in an appropriate place where it does not interfere with her normal development.

The neighbor's curiosity, the reaction by schoolmates, if this is made public information, again, has more, many times a greater effect than the actual assault itself, so we can minimize that . . .

NARRATOR: The examining physician may not be able to be responsible for the long term follow-up of a case. There may be a child protection center, a psychiatric clinic, or other agency to turn to for help.

But we *are responsible* for our attitudes and our reactions towards the people involved in sexual abuse.

DEVINE: We have control over how we react. We can educate people to react in a different manner and then perhaps make an impact on the assault and the results of that assault on the child.

58. Close-up child's face.

59. Small girl in backyard, alone, (playing with dolls). Mother watching from window or door, shot over her shoulder.

60. Girl rubbing or banging dolls together, CU.

61. Mother talking with girl, holding dolls.

62. CU: Girl upset holding doll tight.

63. Doctor on the phone.

64. DeVine in exam room.

65. Child hugging doll, calm.

66. Consultant Credit.

67. Medical photos credit.

68. Staff credit.

69. Staff credit.

70. PROFESSIONAL MODELS WERE USED FOR SOME OF THE PHOTOGRAPHS IN THIS FILMSTRIP.

71. NCCAN/HEW credit.

Unit 6: CHILD PROTECTIVE INTERVENTION

UNIT 6.

Time: 4 hr. 40 min

CHILD PROTECTIVE INTERVENTION

DESCRIPTION OF UNIT:

This unit presents the basic steps in the process of intervention to protect children endangered by abuse and neglect and to provide help to families with abuse and neglect problems. It includes: (1) consideration of professional sterotypes that often cause difficulties in child protective actions; (2) the issues involved in reporting child abuse and neglect; (3) investigation of child abuse and neglect; (4) State reporting laws and local procedures for reporting child abuse and neglect; (5) an overview of case planning and referral; and (6) a decision-making exercise focusing on the comparative seriousness of abusive and neglectful situations.

GOALS:

1. To present information on laws and procedures relating to the reporting of suspected cases of child abuse and neglect in order to help participants define their professional and individual responsibilities to report.
2. To familiarize participants with the child protective investigation process in order to help them understand the purpose and effects of reporting.
3. To familiarize participants with multidisciplinary case planning and referral processes to help participants further define professional and agency responsibilities in providing follow-up treatment and services in substantiated cases of child abuse and neglect.
4. To provide participants with an opportunity to practice decision-making about suspected situations of child abuse and neglect.

OBJECTIVES:

At the conclusion of this unit, participants will be able to:

1. Restate the major provisions of their child abuse and neglect reporting law, including (a) what has to be reported, (b) who has to report, and (3) to whom reports are made.
2. Explain procedures for reporting suspected cases of child abuse and neglect in their community.
3. Explain how the local child protection agency responsible for receiving reports and making investigations responds to reports of suspected child abuse and neglect.
4. Describe how investigation relates to the overall process of child protective intervention.
5. Describe at least two types of critical information that should be obtained in an investigation of suspected child abuse and neglect.
6. List the basic components of the case planning and referral process, and define each component.

RATIONALE:

This unit is meant to convey crucial information on reporting of suspected cases of child abuse and neglect and to provide an overview of the processes that a report initiates. Its underlying philosophy is that participants can more willingly fulfill their own responsibilities as potential reporters when they understand the basic steps that are taken by child protection agencies as a result of their reports. It is very important that information on *the reporting law* and *local reporting procedures* be clearly stated in this unit. No participant should complete the unit with any doubts about *how* to report. Participants should also gain from this unit a sense of professional collaboration; that is, that their roles as reporters (or investigators, case planners or case monitors) are integral parts of an interdisciplinary and interagency effort to protect children and help families. The leader should be especially sensitive to discipline- or agency-related hostilities and misunderstandings and should seek to mediate more effective cooperation, either in the course of the session or, if appropriate, in a special "problem-solving" session with the parties involved.

ACTIVITY	TIME	MATERIALS
1. Introduction to unit and group exercise	45 min.	Easel paper, tape, felt-tip pens for small groups
2. Filmstrip and discussion	30 min.	Filmstrip/cassette recording: "Issues in Reporting Child Abuse and Neglect"
BREAK	10 min.	
3. Film and discussion	55 min.	Film: "Investigating Cases of Child Abuse and Neglect" Resource Paper: "The Investigation Process"
4. Leader presentation and panel discussion	45 min.	Resource Paper: "State Child Abuse and Neglect Reporting Laws and Procedures"
BREAK	lunch hour	
5. Filmstrip and discussion	45 min.	Filmstrip/cassette recording: "Case Planning and Referral of Child Abuse and Neglect" Resource Paper: "Introduction to Case Planning and Referral"
6. Group exercise: Decision-making about child abuse and neglect cases	45 min.	Child Abuse and Neglect Situations Exercise
7. Summary	10 min.	

ADDITIONAL STAFF NEEDED:

At least 2 but not more than 4 representatives from the local child protection agency (and police, if appropriate) for Activities 4 and 5.

SPACE REQUIREMENTS:

One room large enough to accommodate the total group, with space sufficient to spread out for small groups of 8 to 12 participants and wall space to hang newsprint for taking group notes in Activity 1.

EQUIPMENT:

35 mm. filmstrip projector and cassette tape recorder
16 mm. sound film projector
Screen
Extension cord and adapter plug, if necessary
1 large easel and pad of easel paper or newsprint or
large chalkboard, chalk and eraser
Felt-tip markers
Masking tape

AUDIOVISUALS:

Filmstrip/cassette recording: "*Issues in Reporting Child Abuse and Neglect*"
Film: "*Investigating Cases of Child Abuse and Neglect*"
Filmstrip/cassette recording: "*Case Planning and Referral of Child Abuse and Neglect*"

BEFORE YOU BEGIN:

Duplicate any necessary materials, unless there are sufficient copies of **WE CAN HELP Resource Materials** for each participant. Duplicate a copy of "Child Abuse and Neglect Situations Exercise" for each participant. The other necessary materials are the 3 resource papers. Be sure you have a copy of the State's reporting law, with definitions marked clearly. Fill in the necessary information for the leader presentation in Activity 4 from you state's reporting law. Be sure to brief panel members and give them an opportunity to read over the case situations that will be presented to them for discussion in Activity 4. Prepare the matrix for Activity 6. *Preview the audiovisuals.*

PARTICIPANTS' MATERIALS:

Resource Paper: "*State Child Abuse and Neglect Reporting Laws and Procedures*"
Resource Paper: "*The Investigation Process*"
Resource Paper: "*Introduction to Case Planning and Referral*"
Exercise: "*Child Abuse and Neglect Situations Exercise*"

ACTIVITIES

ACTIVITY 1. INTRODUCTION AND GROUP EXERCISE

45 minutes

Introduce goals of unit (5 minutes)

The leader first outlines the goals of the unit on child protective intervention. The goals are:

1. Reporting

1. To present information on laws and procedures relating to the reporting of suspected cases of child abuse and neglect, in order to help participants define their professional and individual responsibilites to report.

2. Investigation

2. To familiarize participants with the child protective investigation process in order to help them understand the purpose and effects of reporting.

3. Case planning and referral

3. To familiarize participants with multidisciplinary case planning and referral processes to help participants further define professional and agency responsibilities in providing follow-up treatment and services in substantiated cases of child abuse and neglect.

4. Decision-making

4. To provide participants with an opportunity to practice decision-making about suspected situations of child abuse and neglect.

Define child protective intervention

The leader defines "child protective intervention" as the process in which a legally mandated agency (usually called a *child protective agency*) responds to a report of suspected child abuse and neglect in order (1) to determine and insure the immediate safety of the child, and (2) to validate the report and initiate any necessary planning to provide needed services to the family. Only in a small percentage of cases does this intervention require court involvement. Unit 7 of the *WE CAN HELP* curriculum focuses entirely on the court role in child protective intervention.

The parts covered in this unit are:

- Reporting,
- Investigation, and
- Case planning and referral.

Multidisciplinary teamwork

Effective child protective intervention often requires a high degree of teamwork among a number of different agencies and professions, each with differing role definitions and differing views of each other. Often these definitions and stereotypes act as barriers to the kinds of cooperation that are needed in child protection cases. The cast of characters in child protective intervention may include:

Social workers,
Physicians
Nurses,
Teachers and school personnel,
Psychologists and other mental health workers,

Attorneys,
Police,
Judges,
Various paraprofessionals,
Neighbors, and
Relatives.

Group exercise: "Professional Stereotypes" (25 minutes) Instructions to group

This first activity is an opportunity to reveal professional stereotypes and expectations in order to examine them and test them against reality.

The leader divides the group into subgroups of 8 to 12 participants each. If the group is multidisciplinary in composition, the leader may divide the group into single-profession subgroups (nurses, social workers, police, etc.). The small groups are instructed to choose two of the professions listed above and to *brainstorm* (not discuss) stereotypes of those disciplines. (For example: social workers are "bleeding heart liberals," police are punitive and conservative, attorneys are narrow-minded, and doctors think they are gods.)

In single-discipline small groups, participants should brainstorm the stereotypes of *one other profession* and *then their own.*

One person in each group acts as recorder to list stereotypes on the easel paper. The leader should remind the groups that stereotypes may be *positive* as well as negative; for example, nurses are caring, or police are decisive.

Divide into small groups

Divide into small groups and brainstorm.

Discussion:

Discuss stereotypes (15 minutes)

The group reconvenes as a whole, with the lists of professional stereotypes taped to walls so that each small group's list can be seen by all. The leader allows participants time to read (and laugh) about lists others prepared. Then the leader asks if anyone would like to raise any questions about any of the stereotypes. Were any of the stereotypes surprising? The appropriate small group may respond to questions raised about any items on its list.

Then the leader suggests that the stereotypes may be exaggerated reflections of actual roles and responsibilities required of the various professions. (For example: Police may be perceived as punitive because they are enforcers of society's rules and have the responsibility to arrest those who break the law.) The leader asks participants to suggest how some of the listed stereotypes are related to professional roles and responsibilities.

ACTIVITY 2. FILMSTRIP AND DISCUSSION

30 minutes
Introduce filmstrip (3 minutes)

The leader introduces the filmstrip, "Issues in Reporting Child Abuse and Neglect." The filmstrip suggests reasons why a variety of professionals who relate to children and families may be reluctant to report suspected child abuse and neglect; then several professionals who actually work in the field of child protection discuss ways they have tried to minimize this resistance and to improve the child protective intervention system.

FILMSTRIP

Show Filmstrip (15 minutes)

Discussion:

Causes of reluctance

The leader points out that a number of reasons were given to explain why individuals fail to report suspected cases of child abuse and neglect. Participants are asked to give several reasons presented. They may be:

- Fear of civil or criminal liability for reporting.
- Belief that reporting is not a part of professional responsibilities.
- Difficulty in identifying possible child abuse and neglect.
- Fear of making an unjustified report.
- Objection to time and paperwork involved.
- Unwillingness to testify in court.
- Belief that child abuse and neglect do not exist in the community.
- Belief by some professionals that they can handle child abuse and neglect problems themselves.
- Fear that reporting will destroy professional relationship with client or patient.
- Belief that reported family or individuals will by unjustly stigmatized.
- Fear that reporting breaches professional confidentiality.
- Unwillingness to report middle and upper income families.
- Belief that reporting will not result in any helpful social or protective services for families and may cause harm.
- Belief that community response to reports is too punitive.
- Uncertainty as to nature of community response to reports.
- Unwillingness to accept sole responsibility for making reports.
- Ignorance of child abuse and neglect reporting laws.

Ways to reduce reluctance

Do participants feel these are realistic reasons? Which are most prevalent in participants' community? Are there other reasons? The filmstrip suggests a number of ways to minimize this reluctance to report suspected cases. Participants are asked to help the leader list some of them. They may be to:

- Understand protections accorded the reporter including immunity for good faith reports and suspension of confidential communications for purposes of reporting and testifying.
- Know how to report, to whom to report and what happens when a report is made.
- Provide clear-cut institutional procedures to govern reporting.
- Provide in-service training on identification and reporting.
- Provide official sanction, support and encouragement for reporting.
- Establish full communications with responsible community child protection agency.

- Understand that reporting is not an act of final judgment, but a communication of concern.
- Give personal support to family after making a report and thus become an ally rather than an adversary.
- Understand reporting as a professional as well as a legal responsibility.
- Remain aware and sensitive to needs and values of differing cultures and socioeconomic groups in making decisions.
- Help the family following a report by trying to secure beneficial community responses to their problems.
- Be aware of community resources and services for families in stress.
- Minimize police intervention and criminal prosecution.

Which of these reasons are most helpful personally? Which would seem to be most helpful within the participants' community?

BREAK

10 minutes

ACTIVITY 3. FILM AND DISCUSSION

55 minutes
Introduce film (5 minutes)

The leader introduces the film, "Investigating Reports of Child Abuse and Neglect," by pointing out that a report to the appropriate agency begins the child protective intervention process. The first step is the investigation. This film includes two dramatizations of investigation; one of physical child abuse conducted by a child protective service worker and the other of neglect conducted by uniformed police. In between these two case dramatizations, several professionals discuss some of the issues raised by the investigation phase of the child protective intervention process. Participants should note especially the different components that are a part of investigation, as portrayed in this film.

FILM

Show film (30 minutes)

Discussion:

Discuss film (20 minutes)
Reactions to professionals to parents

The leader first asks the group for reactions to this film, especially their reactions to the professionals involved (the doctor, the child protective worker and the police) and then to the mothers who are portrayed.

See Resource paper

Using easel paper or the chalkboard, the leader asks participants to help develop a list of the steps involved in an investigation. These steps are listed and discussed in the resource paper, "The Investigation Process," on page 79 of the **WE CAN HELP Resource Materials.** The steps include:

Parts of investigation

1. Obtaining information from the reporter.
2. Checking the records.
3. Obtaining critical information by direct observation and interview to determine:
   a. Safety of child(ren),
   b. Validity of allegations, and
   c. Assessment of family's emotional and functional capacities.

Methods of investigation

The leader asks participants to list the various methods that are used in the investigation. They include:

1. Interview,
2. Observation, and
3. Evidence-gathering (not portrayed in film).

Additional discussion topics on this film are:

- The chances for the success of treatment in cases of child abuse and neglect may be determined by the first interview with the parent, even though the primary purpose of the interview is investigation rather than treatment. Comment on the investigative interviewing styles depicted by the doctor, the child protective worker and the police in terms of their implications for the future willingness of Ms. Garrett and Ms. Brewster to accept help.
- In the middle of this film, Ms. Zapata questions the effectiveness of investigations made by professionals who do not understand the investigated family's culture or language. Suppose, for instance, Ms. Garrett had been Spanish-speaking/Spanish surnamed. How might or should this investigation have been different? What alternatives are available to communities with multiethnic compositions to insure fair and effective investigations?
- Neither of these investigations was performed in cooperation with another agency or professional with a different professional viewpoint and skills (such as social worker and law enforcement official). Can you think of circumstances involving the protection of Amy Garrett or Red and Jennifer Brewster in which such a joint approach might have been preferable to the single agency/profession approach portrayed in the film?

ACTIVITY 4. LEADER PRESENTATION AND PANEL DISCUSSION

45 minutes

Leader presentation (10 minutes)
State reporting law

The leader presents a brief overview of the State's child abuse and neglect reporting law as an introduction to the discussion of a panel on the way the law is implemented in the community.

Use Resource Paper for note taking.

(Participants with their own copies of **WE CAN HELP Resource Materials** should turn to the Resource Paper on page 75, entitled "State Child Abuse and Neglect Reporting Laws." They can take notes, using the spaces provided in the paper to fill in points specific to their own State reporting law.)

The points that should be covered in this presentation are:

1. Review definitions What must be reported?

1. **A review of the definitions** of child abuse and neglect included in the State's reporting law (See Unit 1)

2. Mandatory reporters

2. **Who must report?** All State laws now designate certain individuals who must report cases of suspected child abuse. Most States also have such laws covering suspected child neglect. Our State law requires these categories of individuals to report:

183

____

____

____

3. "Suspected" cases

3. *"Suspected" cases.* Every State requires "suspected" cases of child abuse and neglect to be reported. The term *suspected* is sometimes defined as "reason to believe" or "reasonable cause to suspect."

4. Mandated agency(ies)

4. **To whom are reports made?** The law specifies which public agency or agencies are to receive reports of suspected cases of child abuse and neglect. In our State that agency is (those agencies are):

____

____

____

5. How reports are to be made

5. **How are reports to be made?** In most States, oral reports are to be made immediately, usually by telephone. In our State written reports are required to be forwarded from mandated reporters to the mandated agency within _____ hours of the initial oral report.

6. What information to include

6. **What information should be included in the report?** Some States specify what information is to be included with a report of suspected child abuse or neglect. This information generally includes:

- Name, age and address of child,
- Type of injury or neglected condition, and
- Name and address of parent(s) or caretaker(s), if known.

In addition, it is helpful to the child protective agency if the reporter can provide information on:

- Number, presence and ages of other children in the household, if known.
- Others who know about the situation.

Our State reporting law *requires* the following information to be included with reports from mandated reporters:

____

____

____

____

(This section may be handled by providing participants with copies of a reporting form, if one is used in your community.

7. Immunity

7. **What immunity does a reporter have?** Some potential reporters are reluctant to report suspected

child abuse and neglect because they fear retaliatory lawsuits if the abuse or neglect is not confirmed after investigation. Protection is provided against such actions, however; *every* State's reporting law contains a provision for immunity to the reporter for all reports of suspected child abuse and neglect *made in good faith*. While reporting laws cannot prevent the filing of lawsuits against a reporter, they make successful litigation of such suits impossible, provided the report was in good faith.

8. Criminal penalties for failing to report

8. **What are the criminal penalties for failing to report?** State reporting laws usually contain provisions making it a crime to knowingly fail to report suspected child abuse and neglect. In our State, the law specifies the following penalties for failure to report:

____

____

____

Although criminal prosecution rarely, if ever, occurs for failure to report, some professionals find it easier to report if they are able to explain to the child's family that it is a crime for them not to report.

9. Civil liability

9. **What is the civil liability for failing to report?** Under the law of civil negligence, violation of a statutory duty, such as mandatory reporting of suspected child abuse and neglect, is negligence *per se*, "in itself." That means that if it can be proved that a person willfully or negligently failed to report known or suspected child abuse or neglect, he or she can be sued for the injuries that occurred after the time when a report should have been made. This principle has recently been applied to child abuse and neglect cases in situations in which reports of suspected abuse or neglect were not made. (Further discussion of two cases of civil suits brought against professionals and agencies for failure to report is included in the Resource Paper, "State Child Abuse and Neglect Reporting Laws and Procedures," on page 75 of **WE CAN HELP Resource Materials.**

10. Professional confidentiality are also required by law to testify in child abuse and neglect cases when subpoenaed

10. **What about professional confidentiality?** In every state in which physicians and social workers are required to report suspected child abuse or neglect, they must do so whether or not they have learned of the case as a result of confidential communications with their patient or client. The confidentiality provisions of State law are abrogated by child abuse and neglect reporting laws. Physicians and social workers

Panel discussion (35 minutes)
Introduce panel

The leader introduces panel members who represent the local agency(ies) responsible for receiving reports and making investigations of suspected cases of child abuse and neglect. The panel may consist of three or four individuals. If police are often involved in reporting and investigations, even though they are not the agency mandated by state reporting law, they should be included on the panel. The panel should be briefed beforehand on the purpose and the content of this activity and be ready to answer participants' questions.

Purpose of panel

The purpose of the panel is to present the local procedures for implementing the State reporting law, using three vignettes of suspected child abuse and neglect.

Case report vignettes

The leader reads the following three case report vignettes and, after reading each one, asks the panel to describe how the receiving/investigating agency would handle the report.

1. **Case report No. 1:** A neighbor telephones at 5:30 p.m. on a Friday to say that he has found three children unattended in their home. The children, ages six, four and two, appear to be ill. The oldest has told the neighbor that his mother left for her job at an insurance company two days ago and has not returned since. The two-bedroom house is unheated and in disarray; two windows in the children's room are badly broken. The only food in the house is soda pop, cereal and some hot dogs.

(Panel discussion of Case No. 1)

2. **Case report No. 2:** A junior high school teacher telephones to say that a 13-year-old girl in her class has told her she has had sexual relations with her father on two occasions within the last six months. She does not think she is pregnant, but she isn't sure. Her father is employed, and her mother lives at home. The report comes in at noon. The girl will be in school for three more hours.

(Panel discussion of Case No. 2)

3. **Case report No. 3:** A 30-year-old mother has brought her four-year-old son to the general hospital emergency room in your community with a broken right arm. The physician on duty confirms that the arm is broken and, after ordering full body x rays, discovers spiral fractures of the tibia and fibula of the left leg which appear to have occurred about four weeks ago. He also observes bruises and lacerations on the child's shoulders and back. The mother explains that the child has fallen off his tricycle many times in the past months. The doctor, however, suspects physical abuse and reports by telephone at 3:00 p.m. on a Tuesday.

(Panel discussion of Case No. 3)

Questions of clarification

The leader may let participants ask questions of clarification as the panel moves from case to case or hold all questions until all three cases have been described. During discussion of the cases, the leader should keep strict discipline in holding the group to the task at hand—namely to discuss local procedures for handling these types of cases.

Prepare for possible hostile questions

(In some communities, where lines of communication between child protective agencies and professionals making reports have not been maintained well, questions may be hostile and accustory. For example, "How can you expect us to make reports, when nothing happens as a result?" The leader should foresee such hostility by trying to prepare the panel to handle it and by being ready to step in to keep the discussion on course when participants' questions edge toward speeches of denunciation rather than questions seeking additional information.)

BREAK

10 minutes

ACTIVITY 5. FILMSTRIP AND DISCUSSION.

45 minutes

Introduce Filmstrip (5 minutes)

The leader introduces the filmstrip, "Case Planning and Referral of Child Abuse and Neglect," by pointing out that the next steps in the child protective process are case planning and then provision of treatment services to families, either directly by the child protection agency or by referral to other community treatment resources.

A multidisciplinary/multi-agency approach

The filmstrip assumes a model of case planning, treatment referral and case monitoring that uses professionals from different agencies working together as a team with the child protective agency acting as the team leader. Here again is a situation in which interprofessional biases and stereotypes can form barriers to effective planning and services.

Look for steps.

Participants should look especially for the major steps in case planning and referral, as presented by the filmstrip.

FILMSTRIP

Show filmstrip (13 minutes)

Discussion (with panel):

Discussion (25 minutes)

Participants may want to refer to the Resource Paper, "Introduction to Case Planning and Referral, on page 85 of **WE CAN HELP Resource Materials**, to supplement the material presented in the filmstrip.

The major steps

The leader first asks participants to help reconstruct the major steps outlined in the filmstrip, using easel paper or the chalk board. These are:

1. Assessment,
2. Treatment planning,
3. Implementing referrals, and
4. Case monitoring.

Different terminology in different agencies

The leader may point out that different terms are used for these steps in the process by various agencies. For instance, *assessment* may be called *case evaluation*, *treatment* may be interchanged with *services*, and *case monitoring* is often called *case management*.

Expand on steps

The first steps can be broken down into subparts, as follows:

1. Assessment

    a. Problems,
    b. Needs, and
    c. Strengths
2. Treatment planning
    a. Goals,
    b. Alternative approaches, and
    c. Resources

Local practice/panel

The leader should allow participants to raise questions for clarification of the case planning and referral process. Then the leader asks the panel members from Activity 4 to discuss this process from the perspective of what actually happens in local community practice.

ACTIVITY 6. GROUP EXERCISE: "Decision-making About Child Protective Intervention"

45 minutes

Transition summary

To make the transition from the previous activities to this activity, the leader should summarize the steps in the child protective intervention process:

1. Reporting,
2. Investigation, and
3. Case planning and referral, which includes
    a. Assessment
    b. Treatment planning,
    c. Implementing referrals, and
    d. Case monitoring.

Importance of reporting
Self-referrals

The entire process—the protection of the child and help for families—is usually dependent on the willingness of a concerned and responsible individual to initiate the process with a report. (The process may also be initiated by *self-referrals*—in effect, parents requesting help by reporting themselves. Unit 8 deals with ways to enhance community efforts to prevent child abuse and neglect by making it easier for parents to seek treatment services for themselves.)

Rank cases in order of degree of risk.

The following individual and group exercise gives participants an opportunity to consider child protective intervention in terms of actual cases. The leader passes out a copy of the situational exercise to each participant. Participants are asked to rank these descriptions in order of their seriousness. If you were faced with all of these situations at the same time, which ones would you act on first? second? etc.? On a scale of 1 to 10, #1 equals the most serious and #10 equals the least serious. Participants are also asked to circle the letters of those situations which they would report to the child protective agency.

Participants do exercise individually

Participants should work individually on the situational exercise. Allow approximately 15 minutes, or less if participants have completed their rankings.

Matrix for discussion

The leader should have on easel paper or the chalk board the following matrix for discussion:

(See next page)

Vote on seriousness

When the group has reconvened, the leader has participants vote, first by their rankings: how many voted situation A a "one", a "two", etc. The result should give a profile of which of the cases are considered most serious.

Situation	1	2	3	4	5	6	7	8	9	10
A. Locked up 5-year-old										
B. Bruises/welts										
C. Unsupervised children										
D. Valium to 2-year-old										
E. Shunned child										
F. 5-year-old/special walks										
G. 6-year-old retarded										
H. Dirty and underweight										
I. Eye injury										
J. Parents fighting										

Vote on whether to report

Then the leader has participants vote *yes* or *no* on whether they would report these situations. The votes may be tallied to the left of the letters on the matrix.

Discuss exercise

The leader leads a discussion of the exercise, encouraging participants to explain for each other why they voted as they did, especially focusing on those situations about which the group indicated the widest disparity of opinions.

Finally, the leader can share follow-up information on each situation in order to compare what happened to these children and families with the group's decision-making about the seriousness of their situations.

Here are brief follow-up statements about what actually happened.

A. The mother's actions were based on bizarre religious beliefs resulting in inappropriate, harsh punishment. An elderly father was unable to protect the child. The child was placed in an institution with the mother's approval.

B. The child had become associated with the father in his mother's eyes, and the physical abuse became worse before intervention occurred. (Both parents were professionals.)

C. The neighbor who "kept an eye on" the children reported smelling gas in house in which children had locked themselves. After investigation, arrangements were made to provide after school day care in a family day care home.

D. This child became comatose when cold medicine was also given and was placed in foster care following a long hospitalization and a diagnosis of minimal brain damage. (The mother was a nurse, so no one had investigated earlier signs of lethargic behavior.)

E. This child had been rejected since birth, was diagnosed as (a) "failure to thrive" when brought by child protective worker for a medical examination. The other children were fine. The child was surrendered by parents for placement in foster care.

F. Investigation found that the father *was* behaving inappropriately; i.e. he was fondling the child. The family accepted referral for treatment which has evidently proved successful.

G. The child's developmental deficiencies because of lack of parental care and opportunities to learn exacerbated her retardation. She had to be placed in a home for the profoundly retarded.

H. The child was hospitalized at first because of his low weight and was diagnosed to be severely emotionally disturbed. He was referred for special education classes, and a public health nurse worked with the family to help them understand that neither the child's condition nor the child's deliberate belligerence was their fault.

I. This child later died from a subdural hematoma, and the father is now serving a prison sentence. The father expressed a lack of awareness of the dangers of his own strength and the risk of hitting the child on the head.

J. One child was hit by a vase thrown by the father at the mother and was severely cut, causing paralysis of one side of his face. All of the children were placed in foster care.

Summary

10 minutes
Discussion based on unit learning objectives

The leader may use the objectives for Unit 6 to conduct a summary discussion on the child protective process. The questions to cover in summary are:

1. What are the major provisions of the state reporting law?
    - What has to be reported,
    - Who has to report, and
    - To whom are reports made?
2. What are the procedures for reporting suspected cases of child abuse and neglect in our community?
3. How does our local community agency responsible for receiving reports and making investigations respond when reports are made?
4. What is the signficance of the investigation in the overall child protective process?
5. What kinds of information should be obtained in an investigation?
6. What are the basic components of case planning and referral processes?

TRAINING ON CHILD ABUSE/NEGLECT SITUATIONAL EXERCISE

TASK:

The following is a list of situations which have been observed by your staff while on the job or when making home visits. Rank them according to those situations which you feel are the most serious. (Which ones would you act on first? Are they the same?)

On a scale of 1 through 10, # 1 equals the most serious and #10 equals the least serious.

Circle the letters of those situations which you would report to the child protective agency.

A. A five-year-old child has been locked in his room every day after school for six weeks as a punishment for bad behavior.

A. ______

B. A four-year-old child often has bruises and welts as a result of discipline by his mother for lying and behaving just like his "no good father."

B. ______

C. The parents of two youngsters, ages four and five, both spend most of their time out of the house due to job responsibilities and often don't return home until 7 or 8 P.M. The children are able to let themselves into the apartment, and a neighbor "keeps an eye" on them.

C. ______

D. Parents give Valium to a two-year-old to keep him quiet in the evening because he tends to run around and pester them at night.

D. ______

E. A child of four is not allowed to eat with the rest of the family and is rarely spoken to by the parents.

E. ______

F. A five-year-old child has told her teacher that her daddy takes her on "special walks" in the woods and they "play with their private parts."

F. ______

G. A six-year-old is mentally retarded. Her parents are embarrassed by the girl and keep her locked in the house. She receives no education or medical attention.

G. ______

H. A four-year-old child is found to be considerably underweight for his age. He comes to kindergarten in the same worn and dirty clothes, is in need of a bath, and the other children are beginning to shun him. In response to inquiries, the parents said that they are sick and tired of forcing him to eat and to take proper care of his clothes.

H. ______

I. A father strikes his four-year-old for knocking over a glass of milk. The child sustained a serious eye injury from the heavy ring the father was wearing. The injuries have been medically treated, and the child has just returned to school.

I. ______

J. The parents fight frequently due to financial problems. The father is in the habit of hitting the mother in front of the three children who hide and cry.

J. ______

STATE CHILD ABUSE AND NEGLECT REPORTING LAWS AND PROCEDURES

CHILD ABUSE AND NEGLECT REPORTING STATUTES

Reporting statutes are laws that require specified categories of people (usually professionals who work with children) to notify public authorities of instances of suspected child abuse, and sometimes of neglect. All 50 States now have reporting statutes, but they differ with respect to:

- Types of instances which must be reported.
- Persons who must report.
- Time limits for reporting.
- Manner of reporting (written, oral, or both).
- Agencies to which reports must be made.
- The degree of immunity conferred on those who report.

Several purposes are served by these laws: protection of children from further injury, provision of social services to families and increased identification and investigation of suspected cases of abuse and neglect.

TRENDS IN REPORTING LAWS

The first reporting law for child abuse and neglect was passed in 1963; by 1967 all 50 States had adopted reporting laws. The original laws were directed primarily toward physicians and hospitals, who were failing to report cases in which the child's injuries appeared to be caused by physical abuse. Proponents of these early laws felt that the medical profession was best qualified to identify such injuries and in the best position to discover them. Now, however, most States have expanded their laws to require other professionals who work with children (including educational personnel, social workers, and police) to report suspected abuse and neglect.

Many States are amending their reporting laws at the present time. Generally, the trend of these amendments is toward

- Expanding what is reportable to include sexual abuse and neglect, as well as physical abuse.
- Reporting only to child protective services rather than also to law enforcement agencies.
- Improving the operations of state-wide central registers for child abuse and neglect.
- Establishing clear requirements for child protective investigations.

In our State, the following amendments to the reporting laws are pending:

____

____

____

____

IMPACT OF THE FEDERAL GOVERNMENT ON STATE CHILD ABUSE AND NEGLECT LAWS

U.S. Public Law 93–247, known as the Child Abuse Prevention and Treatment Act, was passed in January 1974 and has had a strong impact on the states. It created the National Center on Child Abuse and Neglect (NCCAN) within the United States Children's Bureau (Department of Health, Education and Welfare); funded demonstration projects and programs throughout the country; and provided grants to states for child abuse and neglect prevention and treatment programs. To qualify for such grants, States must satisfy certain Federal requirements. In the area of reporting laws, these include:

- Provision for the reporting of known and suspected instances of child abuse and neglect, including abuse and neglect of children in residential institutions.
- Enactment of a law giving immunity from prosecution to persons reporting child abuse and neglect.
- Provision that, upon receipt of a report, an investigation will be made promptly,

and immediate steps taken to protect the child and any other child under the same care who may be in danger from abuse or neglect.

- An effective state service delivery system to implement the state child abuse and neglect laws.
- Protection of the confidentiality of all child abuse and neglect records.
- Provision for cooperation among law enforcement agencies, courts, and human service agencies in the area of child abuse and neglect.

The National Center on Child Abuse and Neglect has also developed a Model Child Protection Act, which provides States with a suggested legislative approach to mandatory reporting as well as a comprehensive state plan for the investigation and referral of child abuse and neglect cases. Copies can be obtained by writing the National Center on Child Abuse and Neglect, U.S. Children's Bureau, Department of Health, Education and Welfare, P.O. Box 1182, Washington, D.C. 20013.

MAJOR POINTS IN OUR STATE'S REPORTING LAW

Who Must Report? Each State law designates certain individuals who must report cases of suspected child abuse and neglect. These individuals usually include: health professionals, social service personnel, law enforcement officers and educators. Some States require any person having reason to suspect child abuse and neglect to report. Whether or not required to by law, anyone who suspects child abuse or neglect should voluntarily report. In our state the following individuals are legally required to report:

____

____

____

____

____

What Types of Abuse and Neglect Must Be Reported? All State reporting laws specify what types of abuse and neglect must be reported. Usually, these include physical abuse, neglect, sexual abuse, and emotional maltreatment. In our State, the law specifies that the following types of abuse must be reported:

____

____

____

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It is important to remember that the reporter need not be certain that abuse or neglect is occurring. Every State requires "suspected" cases to be reported. In most States, the requirement is for reports to be made when the reporter has *reason to believe or reasonable cause to suspect* that abuse or neglect may be occurring. In our State, a person must report when:

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To Whom Are Reports Made? The law specifies which agencies are designated to receive reports of suspected cases of child abuse and neglect. Generally, these agencies include any or all of the following: state or county department of social services, law enforcement agency, juvenile court or juvenile probation department, or county health department. In our State, the designated agencies to receive reports are:

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When Are Reports To Be Made? In most States, reports are to be made immediately after forming the suspicion that abuse or neglect exists. In some States, it is necessary to submit a written report soon after the initial oral report. In our State, written reports are (are not) required, within ______hours of the initial oral report.

What Information Is To Be Reported? Some State laws specify what information is to be given when making a report. In other States, the receiving agencies determine what information is required. This information usually includes: name, age and address of the child, present location of the child, type of injury suffered, and name and address of the parent(s) or caretaker(s), if known. In our State, the law (or local agencies who receive reports) require the following information:

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What Immunity Does a Reporter Have? Some potential reporters, such as health professionals, are reluctant to report suspected child abuse and neglect because they fear retaliatory lawsuits if the abuse or neglect is not confirmed after investigation. However, every State's reporting law contains a provision for immunity to the reporter for all reports of suspected child abuse and neglect *made in good faith.* While reporting laws cannot prevent the filing of lawsuits against a reporter, they make successful litigation of such suits impossible, provided the report was in good faith.

What Are the Criminal Penalties for Failing to Report? State reporting laws usually contain provisions making it a crime to knowingly fail to report suspected child abuse and neglect. In our State, the law specifies the following penalties for failure to report:

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Although criminal prosecution rarely, if ever, occurs for failure to report, some professionals find it easier to report if they are able to explain to the child's family that it is a crime for them not to report.

What Is the Civil Liability for Failing to Report? Under the law of civil negligence, violation of a statutory duty, such as mandatory reporting of suspected child abuse and neglect, is negligence *per se,* "in itself." That means that if it can be proven that a person willfully or negligently failed to report known or suspected child abuse or neglect, he or she can be sued for the injuries that occurred after the time when a report should have been made. This principle has recently been applied to child abuse and neglect cases in situations in which reports of suspected abuse or neglect were not made. Two California cases in which a child suffered serious injuries from abuse subsequent to a hospital's failure to report its suspicions of possible child abuse have received considerable attention.

TWO RECENT CASES

Robison v. Wical, MD, et al. (Civil No. 37607, California Superior Court, San Luis Obispo, filed September 4, 1970). Eventually settled out of court for $600,000, this case involved a mother and a boyfriend who brought her young son to a hospital twice in a 12-hour period with severe injuries. Neither time did the hospital report abuse. A day later they brought the child to a second hospital with what turned out to be permanent brain damage. The boy's father sued the first hospital and others for negligence based on the hospital's failure to report the case.

Landeros v. Flood, 17 C.3d–399, ______ Cal Rptr ______, ______ P.2d ______ (1976). In the first State Supreme Court decision of its kind in the United States, the California Supreme Court ruled that a doctor and a hospital may be liable for malpractice for failing to report a suspected case of child abuse. In that case the following facts were alleged: An 11-month-old girl had been brought to the hospital by her mother suffering from a spiral fracture of the right tibia and fibula, which gave the appearance of having been caused by a twisting force. The child's mother had no explanation for this injury. The girl also had bruises over her entire back, superficial abrasions on other parts of her body and a linear fracture of the skull, which was in the process of healing. Without taking full body skeletal x rays, the hospital released the child to her mother and the mother's common-law husband. The hospital made no report of suspected abuse, as is required by California law. Within 11 weeks, the child was brought to a second hospital, having now sustained traumatic blows to her right eye and back, puncture wounds over her left lower leg and across her back, severe bites on her face, and second and third degree burns on her left hand. At this time, the battered child syndrome was immediately diagnosed and reported to the appropriate agencies.

The court's decision discussed the application of several rules of negligence and of the State reporting laws to lawsuits claiming malpractice for failure to report. The court stated that, as a matter of law, the hospital and the doctor could be liable for damages if it could be proven that 1) the doctor was negligent in not properly diagnosing and treating the battered child syndrome, or 2) that the doctor had knowingly failed to report a case in which he actually suspected that the girl's injuries were the result of abuse, or 3) that an ordinarily prudent physician who had correctly diagnosed the battered child syndrome would have foreseen the likelihood of further serious injuries to the girl if she were returned directly to the custody of her caretakers.

Conceivably, a teacher's or social worker's failure to report suspected child abuse or neglect might also be the basis for a lawsuit for damages if the child later suffers injuries as a result of further abuse.

CONFIDENTIALITY AND THE DOCTOR/PATIENT, SOCIAL WORK/CLIENT PRIVILEGE

In every State in which physicians and social workers are required to report suspected child abuse or neglect, they must do so whether or not they have learned of the case as a result of confidential communications with their patient or client. Physicians and social workers are also required by law to testify in child abuse and neglect cases when subpoenaed.

CENTRAL REGISTER

State reporting laws often contain provisions for the establishment and operation of a statewide central register for child abuse and neglect. In some states, such registers are governed by laws other than the reporting laws or by regulations of the state agency which operates the register.

In making or receiving a report of suspected child abuse, the reporter may have access to departmental or other registries containing information about prior abuse or neglect reports. State-wide child abuse and neglect registers are useful in evaluating a suspected case of child abuse and neglect, in that such registers provide information about prior verified reports of child abuse and neglect from every county in the State. Thus, families with prior histories of abuse or neglect can be identified even if they have moved from one county to another. In our State and county, the following registers are available to potential reporters:

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The procedures for using these registers are as follows:

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THE INVESTIGATION PROCESS

HOW INVESTIGATION RELATES TO THE OVERALL PROCESS OF IDENTIFYING, REPORTING, AND REFERRING CHILD ABUSE AND NEGLECT CASES

Investigation is one part of the overall process of dealing with child abuse and neglect. Reporting child abuse and neglect is the first official involvement of professionals in the lives of a family which may *or may not* have an abuse and neglect problem. The investigation process is the second step of involvement and is the direct consequence of the filing of a report. In order to determine the validity of a report, an investigation, no matter how brief, must be conducted. Investigation is a key part of the overall process because the information obtained during the investigation to a large extent determines the subsequent actions or lack of actions taken in a case, including eventually the treatment or services which the family will be provided or referred to.

DEFINITION AND PURPOSE OF INVESTIGATION IN SUSPECTED CASES OF CHILD ABUSE AND NEGLECT

Investigation is a fact-finding process of interviewing, observing and evidence-gathering by which a report of a suspected cases of child abuse or neglect is verified. There are four purposes of an investigation:

1. To determine if abuse or neglect is occurring.
2. To determine whether the child is at risk in the home.
3. To determine whether the risk is serious enough to warrant immediate intervention to guarantee the child's safety.
4. To determine the need for treatment or family supportive services.

Underlying these specific purposes is a general concern for the functioning of the entire family. Investigation of child abuse and neglect involves an authoritative intervention into the normally private relationship between parent and child. To be effective, that intervention must be sensitive to the causes of the child abuse and neglect problem and supportive of the family's right to obtain treatment for those problems.

AGENCIES MANDATED TO INVESTIGATE REPORTS

Reporting statutes of all States specify the agencies that will receive and investigate a report of suspected child abuse or neglect. The agencies most commonly mandated to investigate reports of abuse or neglect include:

- Social service departments (often a child protective service).
- Police departments (often a juvenile division).
- Juvenile probation departments.

Agency Approaches to Investigation:

The approach to the investigation is determined both by the reporting law and by the overall purpose of the agency performing the investigation. In most instances the investigation of reports of abuse and neglect is not the primary function the mandated agency performs and the investigation approach and process have to conform to general agency practices as well as State law requirements. For example, the Department of Social Services has an overall purpose of providing services to families and individuals in need. Accordingly, a social worker conducting an investigation evaluates whether or not abuse or neglect exists in terms of the problems in the home and tries to determine if the agency (or others in the community) can help resolve those problems. Police departments, on the other hand, have an overall purpose to determine whether or not a crime has been committed. During an investigation of suspected child abuse or neglect, a police officer will investigate whether or not abuse or neglect has occurred by finding out who rather than what is responsible for the problem and determining if legal sanctions are required to resolve the problem.

Juvenile probation departments become involved in cases to determine if court involvement is required to obtain adequate parental care for a child. During an investigation of suspected child abuse or neglect, juvenile probation officers will place priority on determining whether or not there is evidence for the court to become involved in the case. It is important to emphasize that the overall purposes of investigation intersect regardless of what agency is conducting the investigation. However, the approach to investigation is to a large extent determined by the internal mandate of the individual agency.

STEPS IN THE INVESTIGATION

Regardless of the approach of the investigation, there are basic steps that every investigation should include. Those steps are:

Step 1. Obtaining Information from the Reporter:

When someone reports a suspected case of abuse or neglect, it is important to obtain as much of the information as possible which will be needed in subsequent steps of the process. The investigator concentrates on getting information critical to locating the family, providing any needed emergency assistance, and identifying additional sources of information on the family. At a minimum this information should include:

- Name, age, address of child.
- Name, address of parents.
- Where parents can be reached (e.g., at home or their place of employment).
- Incident that precipitated the report.
- Present condition of the child.
- Siblings who are in the home.
- Other individuals and agencies that know the family.

Step 2. Checking the Records:

Prior to actually investigating the report, many agencies institute a routine records check on the family which may include such internal agency records as past reports or closed service records; records from agencies such as Juvenile Court, the Police Department, or the Department of Social Services (income maintenance or service cases). Some areas have central registers which keep all reports of suspected abuse and neglect cases—often on a statewide basis. Information that a records check can turn up includes the reliability of the reporter (as evidenced by previous reports he or she has filed), and also the most appropriate agency to assume responsibility (as, for example, if a family is already "active" with another agency, such as Juvenile Probation, because of a previous incident of abuse or neglect).

Records checks can be made for two purposes: 1) to obtain information about whether or not a family is known to an agency or reporting system, such as whether a family is listed in a central register or if the child has been seen at more than one medical facility, and 2) to obtain information about the content of the contact the family has had with that agency or reporting system, such as whether or not a medical clinic suspects abuse or neglect or whether or not the juvenile probation file indicates presence of abuse or neglect.

Step 3. Obtaining Critical Information

a. Safety of the child: The first purpose of an investigation, for obvious reasons, is to make an initial determination concerning the safety of the child. If the child (or the child's sibling) is in immediate danger of further injury, the investigator must take whatever steps are necessary to insure the child's safety before the rest of the investigation can proceed. These steps can involve a number of interventions from obtaining help from neighbors or relatives to care for the child temporarily until the parent is located, to bringing in a homemaker who will care for the entire family in the home, to removal of the child into another environment until the investigation is completed. Deciding that a child should be temporarily removed from the home can be difficult, in view of the disruptions that such removal will cause, but the reality of some cases is that without removal the child could die or be seriously harmed during the investigation itself. Such a decision should involve consultation, at a minimum, with an investigator's supervisor and, if possible, with appropriate medical authorities (in the case of physical abuse). The ideal resource would be a team of professionals skilled in assessing risk to a child.

General situations that could mean a child is in danger and should be removed from the home include, first, the following:

- The maltreatment in the home, present or potential, is such that a child could suffer permanent damage to body or mind if left there.

- Although a child is in immediate need of medical and/or psychiatric care, the parents refuse to obtain it.
- A child's physical and/or emotional damage is such that he/she needs an extremely supportive environment in which to recuperate.
- A child's sex, race, age, physical or mental condition renders him/her incapable of self-protection—or for some reason constitutes a characteristic the parents find completely intolerable.
- Evidence suggests that the parents are torturing the child, or systematically resorting to physical force which bears no relation to reasonable discipline.
- The physical environment of the home poses an immediate threat to the child.

The following findings may signal the need for immediate intervention if they accompany indications of physical injury or physical effects of neglect:

- Parental anger and discomfort with the investigation will be directed towards the child in the form of severe retaliation against him or her. Such information could be gained through a review of past parental behavior, statements and behaviors during an investigative interview, or from reports by others who know the family.
- Evidence suggests that the parent or parents are so out of touch with reality that they cannot provide for the child's basic needs.
- The family has a history of hiding the child from outsiders.
- The family has a history of prior incidents or allegations of abuse or neglect.
- The parents are completely unwilling to cooperate in the investigation or to maintain contact with any social agency.

If the investigation concludes that emergency placement of the child is needed, the investigator should first inform the parent of the reasons for removal. Frequently, the parents will cooperate in placing the child with a relative or friend. If this is not an option, the parents should be urged to cooperate in having the child placed in a temporary foster home or youth shelter. Only when the investigator has made all reasonable efforts to secure the family's cooperation should involuntary removal of the child, by means of some legal action, be implemented.

b. Information concerning the allegations in the report: If the report indicates that a child sustained injuries, the investigator obtains information about those injuries such as the parents' explanation (if any) concerning how the injuries occurred; the child's explanations (if appropriate); and statements from people who observed the incident(s) or examined the child. Parents can also be queried as to what steps they took to protect the child (if they claim the injuries were accidental), what medical care, if any, they gave the child following the injuries, and what medical care—if any—the child has received from other sources. The investigator should also ascertain if the child has been injured before and, if so, should obtain similar information for previous injuries.

If the report indicates that a child has been neglected, the investigator explores the specific allegations with the parents and, if possible, makes direct observations of the child's home environment—especially if the parent contradicts the charges in the report. If, for example, the report states that the child is malnourished and/or without adequate clothing—and the parents deny these charges—the investigator should ask to see the child, and observe the child's clothing and the presence or absence of food in the home. When such observation is inconclusive, the investigator can (with the parents' cooperation, if possible), seek a third opinion—as, for example, from an examination of the child by a doctor or other health professional.

c. Assessment of the family's emotional and functional capacities: Child abuse and neglect do not occur in a vacuum; they are, rather, part of a set of inter- and intrapersonal behavior patterns which can be caused or exacerbated by external stress on the family. While obtaining an extensive history of these behaviors is not the purpose of the investigation, some knowledge of these behaviors is helpful in investigating a report of abuse or neglect (especially if other corroborating information is not self-evident or clear-cut) to determine whether or not they are present. They do not, by themselves, "prove" the existence of abuse or neglect but, in concert with more tangible evidence, they do strongly suggest a family situation conducive to the maltreatment of children. Types of substantiating information to seek include the following:

- How the family provides for a child's basic needs of food, clothing, shelter, supervision, medical care, and schooling.
- Husband-wife conflicts which are "taken out" on the children.
- Personal problems of either spouse which prevent effective parenting, such as mental disturbance or retardation.
- Crises such as loss of job, death of an important family member, or birth of a new baby which could be overwhelming the family.
- The existence of unreasonable expectations concerning a child's behavior (as, for example, requiring a two-year-old child always to be neat).
- Parental demands on children for emotional sustenance beyond what a child can appropriately provide.
- Parental use of physical violence as the primary means of controlling the child.
- Destructive relationships among siblings, or between a parent and another child, that could contribute to the abuse or neglect of the child cited in the report.

d. Involving the child in the investigation: Although the child is the focus of the investigation, his or her involvement in the investigation itself must be handled carefully. Clearly the abused or neglected child, along with any other children in the home, are proper subjects for observation by the investigator at the time of the interview. Deciding whether the child is interviewed should depend on two factors: 1) the impact of the interview on the child (an interview with an investigator could increase the trauma of an already disturbing life experience); and 2) the effect on the child's relationship with his/her parents (interviewing a child could exacerbate an explosive parent-child relationship, causing the parent to become suspicious and/or jealous of the child—or making the child feel guilty for divulging information about the parent). In some cases, the interviewer will have no choice in the matter. The parent may insist that the child be present during the interview—if this is the case, the investigator should take this opportunity to observe the child and parent-child interactions.

There are also times when the investigator must interview the child. In cases of sexual abuse, an interview with the child is generally a required part of the investigation to assess the reliability of the child's story. When a parent states that the child is wild and out of control, the investigator may need to interview the child to evaluate the parent's claims. An investigator may also want to interview a child who is to be removed from the home, or who exhibits anxiety about the investigation. It is not unusual for a child, particularly a teenager, to report abuse or neglect; in these cases the child will be the interviewer's initial contact with the family.

METHODS USED TO OBTAIN INFORMATION NEEDED FOR AN INVESTIGATION

There are three methods that can be used to obtain critical information: interviewing and observing (which frequently occur together), and collecting documentary evidence (such as written records of interviews and observations, medical records, photographs, etc.).

a. Interviewing:

Interviewing is a contact, generally face-to-face, although it can be conducted by telephone, between the investigator and people involved in the report. The investigator can choose to interview any of the following people: the parents, the child, siblings, relatives, neighbors, friends, other concerned individuals, and professionals already involved with the family. The most important interview is with the family, both in terms of getting the most immediate information and in including the family in any other investigative steps.

Interviewing can be used to gain background information about a family, to clarify what has been observed by an investigator and by other observers, and as a means of establishing rapport with a family. The timing, focus and content of the questioning process varies depending on the nature of the case and the agencies and individuals involved. Interviewing can involve a permissive, openended dialogue in which little "hard" information is either sought or obtained, or it can take the form of a blunt interrogation. To some extent, the style and emphasis of questioning is a function of the mandate of the investigator's agency. Police investigators must be concerned with learning the objective facts of a case in order to determine if grounds exist for criminal prosecution. This may lead to a questioning technique which is more direct and precise in its intent. A child protective services worker may be more concerned with determining the overall family situation and may take a more generalized approach to questioning in order to gain confidence and trust of the interviewee, particularly when talking to those directly involved with the suspected abuse or neglect. In some cases, the desired questioning approach will fall somewhere between the extremes of interrogation and dialogue in order to obtain needed factual information *and* establish contact with the family.

b. Observing:

While observation is a critical part of the investigative process, it is also the most subjective. The investigator is literally *looking* for any information which will be useful in the evaluation of the report. But the judgments concerning what to look for and how to assess what is seen are matters both of the investigator's individual skill and discretion. As a result, it is important (whenever possible) to substantiate all observations with objective data and evidence.

WHAT TO OBSERVE:

There are two types of observable data—physical and emotional. Physical information includes the physical setting of the home, such as eating and cooking facilities, cleanliness of bathrooms and kitchens, basic amenities such as beds, lighting, and space. Included also is the degree to which the house is safe and healthy for a child—are there unprotected open windows, exposed wiring, vermin, human or animal waste material, etc.? Is the household in sufficient order to prepare food, allow for sleep and basic daily functioning?

Although information about emotional factors in the family is generally obtained through interviews, observation can often be an important tool in assessing the accuracy of the parents' statements about the emotional factors. For example, if a mother describes her relationship with her husband as supportive and positive, and the investigator observes the husband respond to his wife's distress by leaving the room or verbally attacking her, there is reason to doubt the accuracy of what the mother says about her relationship with her husband.

Other nonverbal messages that can be observed include eye contact between family members; facial expressions of love, support, anger, distrust, and rejection; tones of voice that communicate various emotions; the presence or absence of communication; the willingness to listen, to express feelings, to conceptualize feelings, to engage in physical closeness.

Observations of the parent's behavior can be used to confirm an investigator's assessment of the parent's emotional functioning. For example, an investigator can question in an interview whether a parent has a drinking problem. Often such problems are denied; and observations by the investigator of the parent's speech patterns, coordination, and general physical appearance can be used to deal with that denial if in the investigator's opinion a drinking problem does exist.

It must be stressed that observations are very subjective and by themselves prove very little. Many families, for example, are not very verbal; this "lack of communication" may appear to a highly verbal, middle-class investigator as destructive, when in fact it may indicate nothing more than a different style of relating from the investigator's.

When investigating how parents raise their children, the investigator must always be conscious of how cultural differences and/or differences in life-style may be construed as contributing to abuse or neglect, as well as how any differences in culture or life-style may affect his/her response to the family.

c. Gathering Documentary Evidence:

The third method of obtaining critical information is through gathering documentary evidence, information prepared in such a way as to corroborate or dismiss a report. Included are written records of interviews and observations, and in severe cases collecting physical evidence or reports to substantiate a legal presentation. This method provides a built-in mechanism for balancing the subjective aspects of interviewing and observing, and is crucial if and when a case is referred to the courts. The evidence thus collected gives credibility to an investigator's observations, conclusions, and recommendations, and helps to resolve disagreements over interpretations of a case.

Information of this sort includes primary and secondary evidence. Primary evidence refers to the records and physical material personally collected by the investigator. Secondary evidence refers to evidence gathered from others: medical records, police photographs, records from other agencies involved with the family.

d. Assessment and Case Decision

The final step in the investigation process is assessing the critical information and making a case decision. The assessment process includes:

- A review of the allegations contained in the report.
- A statement of all the facts obtained in the investigation.
- A statement of all the evidence obtained in the investigation that can substantiate the facts.
- An assessment of whether the facts obtained in the investigation substantiate or refute the allegations of the report.
- An assessment of the child's long-term needs for protection based upon the facts and evidence and the investigator's evaluation of the parents' needs which will affect their ability to provide that protection.

The case decision includes the options available to the investigator as determined by the law, agency mandates, and available resources. The final decision should be based upon the facts and evidence in the investigation, the child's immediate and long-term needs for protection, and the investigator's assessment of the parents' ability to meet those needs.

INTRODUCTION TO CASE PLANNING AND REFERRAL

Case planning is a systematic process using assessment, treatment planning, and case monitoring to provide treatment to families with child abuse and neglect problems.

Treatment actually begins with the first contact a family has with a professional or agency as an abusive or neglectful family, which usually occurs at the time a family is reported. Every contact the family has with professionals/agencies thereafter has an effect on the treatment process, either positively or negatively, and can be considered part of treatment. The family will either be helped to confront their problems and difficulties or they will be motivated to resist and avoid the overtures of professionals.

After initial identification, the first decisions confronting the professional or paraprofessional concern any emergency measures necessary to protect the child and/or provide medical services. A report is then made to the appropriate agency and an investigation is undertaken to confirm the existence of abuse or neglect and to begin to identify the problems and needs of the family which create child abuse and neglect dynamics. Investigation and case planning are a continuous process which have been arbitrarily separated in this curriculum to provide an opportunity to study both in depth.

ASSESSMENT

The information collected by investigators is used in the first phase of case planning: assessment. The purpose of the assessment phase is to evaluate social, psychological and medical information to determine the *specific problems* the family is having, possible causes of those problems, and the *needs and strengths* of each family member and the family as a unit. Assessment is a complex, systematic and dynamic process designed to define treatment needs. The family's problems, needs and strengths are continually assessed throughout the treatment process to assure that the help being provided is the help which is needed.

TREATMENT PLANNING

Treatment planning is the second phase of case planning. Treatment planning is the process by which problems and needs of each family member are matched with specific treatment resources or services that can respond to those problems and needs. In this context, treatment covers a broad range of services designed to meet individual needs and solve individual problems of the parents and the child, as well as the problems of parent-child interactions. As presented in the identification units, the parents' inability to care properly for their children is usually related to their inability to satisfy needs of their own. Treatment strives to help parents develop personal resources to meet their own needs, to recognize and meet their children's needs, and to establish satisfactory patterns of interaction between them and their children.

Treatment planning has three components: (1) goal setting, (2) identifying treatment alternatives, and (3) identifying specific resources. The treatment planner sets treatment goals to guide the process of choosing treatment alternatives and specific treatment resources, and to give direction to the treatment professionals as they render their services to the family. Treatment goals are actually behavioral goals for the family to achieve by the end of treatment. They help focus professionals and paraprofessionals on what the family can be expected to accomplish in treatment, and what particular behaviors indicate that treatment has been successful. For example, a treatment goal for parents experiencing marital conflict which is contributing to the abuse or neglect of their three-year-old son might be for the parents to resolve their marital conflict and provide each other with support in child rearing. When these goals have been reached, the treatment has been effective. "Treatment alternatives" is the generic name for the variety of modalities and methods of providing treatment. The treatment alternatives considered in planning treatment for child abuse and neglect cases should reflect the special needs of each family very specifically. For example, abusive families are frequently socially isolated, dependent, and have strong needs for friends and outside support. To meet these needs, treatment alternatives such as parent or family aides or group therapy with other abusive or neglectful parents are most effective because they provide support, nurturance, and peer interaction, as well as the opportunity to confront problems in a therapeutic setting. These treatment forms meet a number of needs in addition to providing an opportunity to solve problems. Defining treatment alternatives is a demanding task because it necessitates looking very specifically at several complex issues at the same time: the problems of the family, the possible causes of those problems, the overall needs and strengths of the family, and the treatment goals. The treatment planner must, therefore, know and understand the social, cultural, and psychological factors that consistently contribute to abuse and neglect. In addition, the process of defining possible treatment alternatives must focus on finding the level and style of treatment most appropriate for each family member and to the family as a whole.

Choosing treatment resources, the last component of treatment planning, should also be a creative and dynamic process. Potential resources should be evaluated to determine what specific services they offer (e.g., family therapy, parent aides, parent's groups, etc.); their philosophy of service; and the style of treatment delivery (e.g., home visits, weekly office visits, etc.) to determine if, in fact, they can accomplish the specified treatment goals and if they use appropriate treatment alternatives. The treatment resources/services should be continually evaluated and re-evaluated as to the effectiveness of the treatment they are providing, just as the assessment of problems, causes, needs and strengths must be continually assessed to ascertain if the right problems and needs are being treated.

Choosing treatment resources is a process of reconciling the ideal with the real. The treatment planner should approach the task of defining treatment alternatives with the assumption that all potential treatment resources are available in the community. Then he/she must evaluate the actual treatment alternatives available in the community to create the closest approximation of "ideal" treatment at his or her disposal. Sometimes, one resource will meet only part of a treatment goal or provide only part of the services possible with the "ideal" treatment alternative. In this case, the resource must be supplemented by other resources to achieve an optimum treatment package; this is the essence of choosing a treatment resource. For example, a treatment goal might be for a mother to gain socialization skills in order to develop personal support systems. The chosen treatment alternative is a parents' group for abusive and neglectful parents in which she could make some friends at the same time that she is learning to understand her own needs for support as well as the needs of others. The treatment planner learns that no such group exists in the community, but a search uncovers a mother's group sponsored by the County Health Department. Such groups are organized at the neighborhood level and are designed to provide support for young mothers and to teach child development. They provide a viable alternative to the treatment planner's first choice, with some additional support from another source to help the mother with learning to trust others and developing healthy give-and-take relationships.

CASE MONITORING

Case monitoring (or case management) is the third phase of case planning. Case monitoring ensures that case planning is effective. The case monitor/manager is responsible for seeing that the case plan is successfully carried out and that treatment is effective. The case monitor may be an individual or an agency who is mandated or who volunteers to follow the progress of a case. The case monitor has continuing contact with the family, the treatment agencies, and the individuals working with each family member and the family as a whole. His or her role is: (1) to act as a mediator when problems arise between a family member and worker, (2) to reinstitute the treatment planning phase when treatment proves ineffective, and (3) to provide support for the workers in maintaining treatment relationships and preventing professional "burn-out"—a serious problem among professionals and paraprofessionals involved in child abuse and neglect cases. "Burn out" occurs because of the strenuous personal demands made on the treatment professional in working with abusive families. Abusive families often have severe and complex problems which require time and extreme patience to overcome. The treatment professional may not be prepared for repeated frustrations and disappointments as treatment proceeds; and the extreme demands of time and emotional investment can become exhausting. The case monitor should be prepared to support the worker and to intervene before the point of personal and professional over-extension is reached.

If treatment proves to be ineffective, the problems and treatment needs of the family must be reassessed and a new treatment plan developed. Many things can cause treatment to be ineffective. For example, a treatment modality may be unacceptable to the family, or a treatment agency may not be culturally suited to a family's needs. When problems arise in the treatment, the case monitor must return the case to the treatment planners or assume the role of the planner him/herself. It is important to recheck the original assessment to either confirm or revise the evaluation of problems, needs and strengths of the family, and possible causes of abusive dynamics. Treatment goals, alternatives, and resources also need to be re-evaluated and perhaps a different direction plotted for treatment. A miscalculation in the assessment or treatment plan could be the cause of ineffective treatment as well as unforeseen problems with service delivery as discussed above. The case monitor/manager's role calls for exceptional sensitivity and the ability to balance the continuing needs of both the family and the professionals involved in a case.

Many professionals may be involved in case planning and referral. The professionals who usually have major responsibility for treatment planning are Child Protective Services workers.

In addition, hospital personnel are frequently involved in treatment planning when a report of suspected child abuse or neglect originates in a hospital. In these cases, the hospital may take on primary responsibility for case conferencing, involving all hospital personnel and representatives from community agencies who have been involved with the family. Some communities have developed multidisciplinary child abuse and neglect councils to act as the primary body for case planning and referral.

Those professionals and agencies not mandated or directly involved in case planning and referral are still important to the process. Teachers, police, probation officers, day care workers, public health or community health nurses and others may all have valuable information about the family or individual family members. Their input is essential in developing a comprehensive profile of the psychological, emotional, social, and cultural factors affecting each family member. Many of these professionals and paraprofessionals have had extensive experience with the family or especially significant experiences have given them special understanding of the family's dynamics which can be very helpful in assessment and treatment planning. They may also offer valuable services as treatment alternatives for family members.

Each phase of the case planning and referral process must continually respond to individual and family problems and needs until treatment has been successfully terminated. It is important for each individual involved with an abusive or neglectful family to understand the case planning and referral process in order to effectively contribute to the treatment of families in crisis.

PROGRAM TITLE: *"Issues in Reporting Child Abuse and Neglect"*
SOUND FILMSTRIP
15 minutes—81 frames

DIALOGUE

NARRATOR: National interest in the problem of child abuse and neglect has become widespread. Concern has led to the adoption of laws governing the reporting of suspected child abuse and neglect.

By 1967, all 50 States had reporting laws specifying who must report and what types of abuse must be reported; many had penalties for failure to report.

A nationally recognized authority speaks about these laws.

DEAN PAULSEN: The first reporting laws focused on physical abuse. Originally, many States required only doctors to report.

Because many children were found to suffer forms of maltreatment other than physical abuse, the laws have been revised.

Many States now require reports of suspected sexual abuse, neglect, and (in some cases) emotional maltreatment as well.

The categories of professionals required to report have also expanded to include health care professionals, law enforcement personnel, social workers, psychologists, child care workers and teachers. In the majority of States, they are now all legally obligated to report suspected cases.

NARRATOR: Are there provisions in the laws that protect the reporter?

PAULSEN: In almost every State, a reporter is granted immunity from civil or criminal liability, if the report is made in good faith.

VISUALS

1–a Focus frame

1–B *We Can Help . . .*

1–C Unit Titles

1–D NCCAN/HEW Title
1. Program Title: *ISSUES IN REPORTING CHILD ABUSE AND NEGLECT*
Super over sketch of small child suggesting neglect.
2. Abused child CU of child with blackened eyes.

3. Med. Wide: Dean Paulsen seated at desk in his office.
Super: His name/title MONRAD PAULSEN, DEAN, UNIVERSITY OF VIRGINIA LAW SCHOOL

4. Silhouette of child in dark room.

5. Dirty-faced child (suggesting neglect).

6. GRAPHIC: List of people required to report with . . .
Supered-over slide # 1 sketch.

7. Split screen of doctor, teacher and policeman.
8. Classroom of schoolyard. Teacher in activity with children.

According to the reporting laws in almost every State, doctors who report suspicions of child abuse or neglect—in good faith—are not violating privileged communication with their patients.

NARRATOR: Are the laws effective?

PAULSEN: Laws have been effective to a certain degree. We have seen enormous overall increases in the total numbers of reports.

However, surveys tell us that some childcare professionals remain reluctant to report.

TEACHER: I'm not a doctor. How can I know if an injury is accidental or not? Child abuse is a problem for physicians and social workers, not teachers.

(PAUSE) And what if I do report and I'm wrong?

DOCTOR (PRIVATE PRACTICE): If I report a case of child abuse, it usually means interviews with social workers and police . . . Sometimes, testifying in court, which can be very uncomfortable—and time consuming.

We rarely see child abuse or neglect in this community, anyway.

Unless it's an *extreme* case—I'd just as soon deal with the problem in my own way.

NARRATOR: How much easier it would be if the problem simply didn't exist.

But . . . it does.

It becomes easier when people know exactly *how* to report and what *happens* when they report.

MARGARET NICHOLSON (Director, Family Center, Adams County, Colorado): The administration of our schools has clearly defined policies to support and encourage reporting.

We make sure all school personnel know the exact procedures to follow in making a report . . . whom they should report to, what information to give in the report, and what happens once the report is made.

In service training programs for teachers, as well as all other school personnel, stress the importance of prompt reporting and how to identify abuse or neglect.

Knowing just *who* in an agency will receive and process your report *can* be important to the reporter.

So . . . (PAUSE) . . . we have identified—by name—specific contact people in the Child Protection Agency.

That way, our school people know who to go to if they have a question, and who to stay in touch with to find out the results of their report. In the two years we've been here, the number of reports has increased dramatically.

JUDGE DELANEY: Reporting Laws only require that you suspect child abuse. Reporting alone is not enough, it is investigation and ultimately the court that determines

9. Doctor looking at x ray.

10. Dean Paulsen sitting at desk.

11. Abused child being examined by doctor. (URSA slide)

12. CU: Teacher facing camera.

SUPER TITLE: TEACHER

13. Teacher in classroom, children in foreground.

14. Doctor gesturing to camera.

Super Title: DOCTOR—PRIVATE PRACTICE

15. Wide on suburban, upper class community—manicured lawns, etc.

16. Doctor in office (from #14)

17. Woman and two children in park. Everyone happy.

18. Abused child—hand has been burned.

19. Woman looking at child's hand in #18.

20. Margaret Nicholson

Super title: MARGARET NICHOLSON DIRECTOR, FAMILY CENTER, ADAMS COUNTY, COLORADO.

21. WIDE SHOT: meeting of counselors.

22. CU of woman in group #21.

23. CU on man in group of #21.

24. CPS worker on phone.

25. Margaret Nicholson

26. Judge Delaney with name title supered: JUDGE JAMES DELANEY

if, in fact, abuse or neglect has occurred.

Without a report, there may be no investigation . . . And without investigation by professionals trained in this area, there may be no action leading to services for children and families in need.

The law is too little used in abuse and neglect cases. Each such case involves important rights, rights of the parents, rights of the child and rights of the community.

Protective Service Workers should not assume they can identify and protect these often conflicting rights or interest. They need the fact-finding help a court offers, their clients are entitled to due process of law.

These important decisions should not rest solely with the case worker, they should be shared decisions which have the sanction and the support of the law.

TALCOTT BATES, M.D.: Through the years I've learned that reporting a possible case of abuse or neglect is not an act of betrayal . . . It's a helping act for all concerned. In *fact*, reporting can save a child's life.

When I am faced with a reporting situation, I sit with the family and explain my legal responsibility to report.

I make it clear . . . I'll still be their doctor and help them in any way I can. If they want a lawyer, I recommend someone who is knowledgeable in child abuse and neglect law.

Parents who are having difficulty rearing their children need allies. In fact, I often find that the real reason parents bring their children to me in the first place is that they want somebody to recognize the problem.

I try to give whatever guidance and support I can. I'd rather report and be wrong . . . than say nothing and find out later, I should have.

ELSA TEN BROECK: I think the reason that people are reluctant to report is because they're afraid that they're not helping people and if they don't understand what the resources are and how identifying someone and bringing them into a system can improve a situation for children and for parents, then no one is going to feel comfortable about reporting and the reporting system isn't going to improve.

I think, often times, parents are initially angry but I have learned in my own experience that when the whole situation is over . . .

. . . often they will come up and say, I'm really glad something happened because I didn't want to kill my kid, and that's the essence of it.

Sooner or later without intervention, we know, and it is well documented, that children will die and, therefore, what I believe is that you should be honest with people,

DISTRICT COURT
BRIGHTON, COLORADO.
27. Ext. CU: Bandaged arm of child.

28. Wider: Shot reveals child with bandaged arm in crowd.
29. Policeman talking to parent.

30. Judge Delaney

31. Super name and title.
TALCOTT BATES, M.D.
DISTRICT CHAIRMAN,
CHILD ABUSE
COMMITTEE, AMERICAN
ACADEMY OF
PEDIATRICS. MONTEREY,
CALIFORNIA
over picture of Dr. Bates
32. Silhouette: A doctor (can be one other than Bates)—reviewing x ray on light box showing distinct fracture.
33. Doctor—confers with one parent in office. Doctor's POV.

34. CU: Parent(s) from #33, expression worried.

35. MED. SHOT: BATES

36. Med. Wide: ELSA BROECK Super name & title: ELSA TEN BROECK,
FORMER DIRECTOR,
EXTENDED FAMILY
CENTER, SAN FRANCISCO

37. Father kicking child.

38. Father consoling child. (same father and child of #37)
39. Elsa Ten Broeck

you should be helpful, you should point out to them exactly what's going to happen, not make any promises but simply help them through each step of the way and that's when reporting makes sense.

NARRATOR: There is a growing concern that only cases of neglect or abuse involving the poor or minorities are reported.

JUDGE SYLVESTER WHITE: It could be that there's a greater incidence of child abuse and neglect in those families but I don't think that's the principle reason. I think the principle reason is that these phenomena are presented to the court usually through public agencies and poor people have more contact with public agencies.

Private schools, private physicians and whatnot would be much more reluctant to report it than public agencies would.

EVELYN BLANCHARD: Reporting is useful only if it means that people will receive help and services. Too often those services available to ethnic people are meager and inadequate.

Services that do exist are often administered by people *unfamiliar* with Native American values... People with little understanding of *our* family dynamics. . . of *our* problems.

Too often, Native American children—identified as victims of a neglect—are often taken from their families . . . and placed in non-Indian homes. Many never see their families again.

In some states where Native Americans have gained participation in agency decisions they are helping to define child abuse and neglect within the context of their community to safeguard against misapplication of the reporting system, this insures maintenance of the Indian family.

In those States, reporting has a better chance of resulting in services reaching families . . . help which supports the integrity of family life.

JUDGE SYLVESTER WHITE: I would like to think that our social workers are not judging, for example, neglect by middle class white standards. However, we in the law have been working with some statutes which don't give us much guidance, either.

And there is abroad in the land the thought that we ought to define neglect, for example, not so much in terms of the parent's conduct but rather in terms of the harm to the child.

Now that gives you more of a specific. It's easier to evaluate whether a child is being harmed than it is whether a parent is being neglectful.

For example, you could get a parent that's a hopeless drunk, now we wouldn't approve that conduct, he

40. SPLIT SCREEN: Tenement with 3 children.

41. Judge White—super name & title: JUDGE SYLVESTER WHITE, PRESIDING JUSTICE, JUVENILE COURT, COOK COUNTY, ILL.

42. Dept. of Public Social Services.

43. Evelyn Blanchard—super name & title: EVELYN BLANCHARD, PROFESSOR, INDIAN STUDIES CENTER, UNIVERSITY OF WASHINGTON, SEATTLE

44. Indian family with design superimposed.

45. Indian child with Caucasian adult.

46. Indian professionals in conference.

47. Evelyn Blanchard

48. Judge White sitting at desk facing camera.

49. Children walking down street.

50. Three children on steps.

may or she may not be giving appropriate attention to the child so we're saying the child is being neglected. But on the other hand, if the child is prospering and getting his own cereal and loving his parents, it would be a little bit ridiculous for me as a judge to make a finding of neglect. Although the parent isn't the best parent in the world, the child is prospering.	**51. Man drinking.** **52. Children playing on steps.**
So I'm inclined to think that the development of the law will be in the direction of the harm to the child rather than the worthwhileness of the parent's behavior.	**53. Judge White.**
NARRATOR: Concerns with community responses which are overly punitive, inadequate or inappropriate echo throughout many professions.	**54. Police officer walking beat.**
POLICEMAN: What's the use in reporting . . especially if nothing is going to happen. Sure, a lot of papers might get shuffled. But then I find the same child—two weeks later—in the *same* situation.	**55. Police Officer—drinking coffee.**
SCHOOL NURSE: What really bothers me is when families are broken up and children are sent to foster homes. That's not the only solution. Lots of times a family wants to stay together and work things out.	**56. School nurse examining child.** **Super: SCHOOL NURSE**
UROYOANA TRINIDAD: As the court and criminal and social service system is now structured it is horrible for families involved in child abuse and neglect.	**57. CU: U. Trinidad Super name & title: UROYOANA TRINIDAD DIRECTOR, EXTENDED FAMILY CENTER, SAN FRANCISCO**
I think that most adult probation people, I'm saying most, not all, do view child abuse and neglect as a criminal act and to be punished, not to be treated, not to be understood, but to be punished. And their treatment of the families are in accordance with that, that's where the values are coming from.	**58. Police talking to man.**
I think it's very important to change the shift in child abuse from punishment to rehabilitation, from just court supervision to some kind of real help. Going to court doesn't help the family, that's been proven, there's plenty of documentation to that.	**59. U. Trinidad in front of Extended Family Center.**
Sending the parent to jail for sure does not help the family, there's been much documentation to that.	**60. Patrol car leaving scene.**
So it's not documentation that we need, it's some action, and the ironic part is that to replace the court and criminal system with treatment programs is a much more inexpensive way of dealing with the problem.	**61. CU: U. Trinidad**
JUDGE SYLVESTER WHITE: Social workers are by nature inclined to think that the use of their skills is a solution for the families problems and, I guess, those who come from a law background don't have quite that much faith in it. And there are some of us in the law who regard it a bit strange that a parent who,	**62. Med: Judge White**
for example, might break his child's jaw and as a result he would be reported to an agency that would use social work techniques to cure the family problem, yet this same man, if he broke his neighbor's jaw, would be reported to the police and thrown in jail.	**63. Adult hitting child's jaw.**

Now does society feel that the breaking of a jaw of a child is less culpable than breaking your neighbor's jaw?

So what I'm saying is that we have a conflict of professional outlook and philosophy as to how we should handle cases of abuse even after they're identified.

SERGEANT JACKIE HOWELL: Problems as complex as those of child abuse or neglect both need and deserve high priority in all agencies and improved interagency cooperation.

Mutual assistance and cooperation between agencies save time and provide us with a more comprehensive picture of each situation to insure that the basic rights of both child and parent are provided for.

An important part of our job after making a complete and objective investigation is ensuring prompt and thorough feedback to each person who makes a report. It's important for people to know what happens as a result of their action.

We also find it important to have someone in our unit available 24 hours a day, seven days a week, to advise or assist on emergency calls.

Police traditionally maintained a rather conservative approach to child abuse and family crisis situations. However, the problem is of such magnitude that they are needed to take a more active role, participating as case finders as a preventative aspect.

Protective Services are or should be as much of a police role as apprehension and prosecution of criminals. Child abuse is *everyone's* job.

MARGARET NICHOLSON: We have a multidisciplinary child abuse committee with representatives from the police, the school system, the medical community, the courts, and Children's Protective Services.

We meet regularly to consider special case problems and we provide consultation . . .

. . . to anyone having difficulty deciding whether a situation, in fact warrants a report.

I find it *really* important to be able to share and consult with *others* in deciding what action is most appropriate for the child and the family.

NARRATOR: People are more likely to report if they know what will happen. That means public information and education.

We need systematic programs—seminars, media, literature—to inform people how to report, and how reporting can initiate important results.

Public information programs, child abuse and neglect councils, interdisciplinary cooperation, provisions for feedback to reporters on case disposition, in-service training, interagency liaison personnel, hotlines . . .

All across the country, the importance of reporting suspected cases of child abuse and neglect is being recognized.

64. CU: Adult hitting child in jaw.
65. Split screen of policeman and Trinidad.

66. Sgt. Jackie Howell—super name/title. She speaks to camera.
SERGEANT JACKIE HOWELL CHIEF, CHILD ABUSE AND NEGLECT UNIT, LOS ANGELES POLICE DEPARTMENT
67. Policeman on car radio.

68. Sgt. Howell at desk.

69. Detective on phone.

70. Police officer with children.

71. Sgt. Howell.

72. M. Nicholson talking.

73. Long shot of group meeting.
74. CU on one of members of group.
75. Nicholson listening to speaker in group.

76. CU: teacher with child.

77. Reprise: seminar from #73.

78. Split screen: Abused children and reporters.

79. Split Screen: Abused children and reporters. (Center shot of abused child replaced with part of hand shot #81)

Programs are being created to remove obstacles that keep potential reporters from taking that important first step.

Child abuse and neglect is everybody's problem. (PAUSE) Reporting is the first step in solving it. (PAUSE) If you don't report it . . . who will????

80. Split Screen: of reporters from #79.

81. CU of hands of adult and child.

CREDITS

END

PROGRAM TITLE: *"Case Planning and Referral of Child Abuse and Neglect"*
SOUND FILMSTRIP
15 minutes—109 frames

DIALOGUE	VISUALS
	1-A. focus frame
	1-B. *WE CAN HELP . . .*
	1-C. Unit 10 . . . .
	1-D. NCCAN/HEW Title
WOMAN'S VOICE: The mother is evidently an alcoholic. She's not giving any attention to her child.	1. Snapshot of a family—a typical family album photo. Everyone is half-smiling.
What about the alcoholism program at the mental health center?	2. MCU: Woman #1 at a table, looking up from a report in her hand. Super: CASE PLANNING & REFERRAL OF CHILD ABUSE & NEGLECT
MAN'S VOICE: These parents don't seem to know how to raise their children. The only discipline they can think of is to knock the kids around.	3. Snapshot of another family.
Maybe a community health nurse or a lay therapist could help.	4. MCU: Man #1 with report in hand, (same setting as Woman #1).
WOMAN'S VOICE: I wonder how we can help this family. The parents won't speak to each other. The older brother beats up the younger one. I think family therapy is the only way to go here.	5. Snapshot—third family. Two children. Variety of expressions on their faces.
ANOTHER VOICE: Well, Margie, I don't know if I can agree with that. My feeling is that this family wouldn't accept anything with the label "therapy" . . . (FADING OUT UNDER NARRATOR)	6. Wide shot—a conference: 3 or 4 people sitting at a small table in an agency setting. All are involved in discussion. Man #1 and Woman #1 are there. Papers are spread out on the table.
NARRATOR: Maybe you've been in this situation yourself.	
Trying to decide what to recommend in a case of child abuse or neglect.	7. MS: Three of the people involved in discussion.
Trying to determine what the problems and needs of the family are.	8. Group. Concerned expressions.
We do it all the time—it's not an easy process. Sometimes it works. Sometimes it doesn't.	9. Same conference.

The client stops going for treatment—or never starts.

Perhaps you've failed to establish rapport—or misinterpreted their problems.

Or the agency you've referred them to isn't meeting their needs. Or there is no program for what they need. These are the kinds of difficulties we all face.

But what can you *do* about them? How can you be more certain that you *do* understand the family, that the clients are in the right treatment, and that the treatment *is* working?

Have you ever analyzed the processes you go through? Or the system you use to make decisions?

Let's look at case diagnosis and referral by breaking it down into four parts, and examining each part individually.

The first is needs assessment. Here we look at . . .

The problems, both obvious and less obvious, the underlying needs, and the strengths of the family. We ask: "What's preventing the parents from caring for and protecting the child? What does the family need to function effectively?"

CHILD PROTECTIVE SERVICES WORKER: I'm with the Child Protective Services and recently I've been working with the Lee family.

Jerry Lee was admitted to the hospital several months ago—his father said his injuries were due to a fall.

A review of Jerry's medical history showed he had suffered another fracture just one year before. Both the doctor and medical social worker suspected the injuries had been inflicted.

10. Split screen:
1. CU one member of the group on the phone—looking concerned.
2. Somebody on the phone in a different agency.
11. CU Social Worker trying to communicate to parent.
12. CU: Social Worker from #11.

13. Client with doubtful expression.

14. MS: Client and Social Worker. Social Worker moved closer, is talking with client—sympathetic mood.
15. Graphic illustration: In the background are silhouetted figures or symbols of a fan. Very subdued treatment so that type can be supered or read easily.
Super type:
CASE DIAGNOSIS AND REFERRAL
NEEDS ASSESSMENT
TREATMENT PLANNING
IMPLEMENTING THE REFERRAL
CASE MONITORING
16. Same graphic—except the type *needs assessment* is highlighted with a strong color.
17. Lee family: Snapshot attached to folder.

18. CPS Worker (a man) on telephone.

19. Jerry Lee being admitted to the hospital. Doctor examining him. Father in background.
20. Doctor and medical SW looking at x ray.

I received their report and visited the Lee home to determine the origins of Jerry's injuries and to begin gathering the information necessary towards understanding the family's problem.

Jerry Lee's father is an aerospace mechanic and had just been laid off with little hope of finding a job. He was scared and anxious about the future.

Mrs. Lee, mistreated as a child and having grown up poor, was full of anxiety over financial problems. She felt Jerry's father didn't listen to her or understand her.

Shy and retiring . . . with few friends or family . . . she found little relief from mounting frustration.

After Jerry was born, Mr. Lee felt that Jerry had come between him and his wife. He has always felt that Jerry receives the attention he himself wants and needs from Mrs. Lee.

Both parents feel they are staying in a difficult marriage for the sake of their son—an only child.

Now four years old, Jerry has become *very active.*

I began to think over the Lee family's situation. What did they need to *cope* with their situation?

NARRATOR: In looking at the needs of a family, we have to consider each member, because each of these personal needs may be contributing to the abuse or neglect of the child.

Be careful to differentiate between *problems* and *needs.* It's easy to focus on problems—and then go straight to what seems like an obvious solution.

Like to say, "This parent is an alcoholic, so let's send him to an alcoholism treatment program."

Alcoholism is a serious problem. It can be hard to look beyond that and identify his needs. He might need to feel that people really care—he might need support from friends.

In the Lee case, Mr. Lee is out of work. That's a *problem.*

But what's behind it? What's his need? He may need vocational counseling. He may simply need a job.

Or, he may need to gain the self-confidence necessary to find one.

Obtaining all the information necessary for a useful needs assessment is not always easy.

You may need social histories, medical histories, and psychiatric evaluations. Sometimes you have to do the best you can with limited resources.

Sharing information with other professionals can often fill the gaps.

CPS WORKER: It's hard and a little frightening to be totally responsible for determining what's going to happen to a family in trouble.

21. Lee home. (The Lees are a middle-income family.) CPS Worker talking to Mr. and Mrs. Lee—sitting at the dining room table having coffee.
22. CU: Mr. Lee (from scene before). Hand to his chin.
23. CU: Mrs. Lee (from scene above).

24. Mr. and Mrs. Lee talking with CPS Worker.
25. Jerry: Baby portrait.

26. Jerry: CU at present age. He looks a little sullen.
27. Jerry: arm in a cast.
28. MCU: CPS Worker working at his desk.
29. Multi-image: head shots of Mr. Lee, Mrs. Lee, and Jerry—separated by black space.
30. Same as # 17: add super:
ASSESS PROBLEMS ***THEN ASSESS NEEDS***
31. MS: A man, drinking. Home setting.
32. MS: Same man, looking depressed.

33. Mr. Lee in an unemployment office.
34. Mr. Lee (in same setting)
35. MS: Mr. Lee talking to unemployment worker. Mr. Lee looks discouraged.
36. CPS Worker doing research.
37. Multi-image:
1. CPS Worker taking notes on a pad while talking to a client.
2. Doctor talking.
38. CPS Worker talking to co-workers.
39. CU: CPS Worker. Side view.

My supervisor is one of my most important resources . . . for helping me decide what might work best as well as sort out my own feelings.

And by consulting other professionals, I can get feedback and support, and take some of the weight off my own shoulders.

In the Lee case, I set up a case conference with the doctor who had treated Jerry, and a Public Health Nurse.

PHN: Mr. Lee shows a great deal of anger toward Jerry. I think he sees his relationship with Jerry as a reflection of his helplessness—another part of his life that is out of his control.

DOCTOR: Let's not forget Jerry's medical condition. How are we going to make sure he's not reinjured?

CPS WORKER: Mrs. Lee seems to have difficulty reaching out to people—including her husband. If only there were more communication between the parents.

DOCTOR: But what about the strength in this family? They do seem committed to staying together. We should work with that in mind.

CPS WORKER: We begin to identify the needs of each person in the family. Jerry needs protection and medical care.

Jerry's father needs help finding a new job. He also needs help in dealing with his role as a parent and his conflicts with Jerry.

Mrs. Lee needs to build communication with her husband and needs to learn how to maintain relationships outside the home . . .

And both parents need counseling and support.

NARRATOR: When the needs of the family have been determined, the next step is treatment planning.

Treatment planning is where we match the needs of the family with the resources and services available in the community.

How do we identify the right resources, the resources which will meet the family's particular needs?

Treatment planning is often hard because some communities have only a few *obvious* resources.

These same resources are often used over and over again—and a lot of families are referred to services that can't really meet their needs—

Like placing a family in psychotherapy when what they really need is someone who can give them support

40. CPS at desk of female supervisor.

41. CPS Worker consulting other professionals.

42. CPS Worker, doctor and PHN (woman) in conference.
43. PHN talking.

44. Doctor and PHN.

45. CPS Worker, PHN and Doctor.

46. Doctor talking at desk.

47. Close-up on Doctor's hand. He has written: "Jerry—medical care—protection."
48. Same as #47, but add to the writing: "Father—needs vocational guidance—needs help on parent role".
49. Same as #47: but writing reads: "Mother-build communication relationships outside the home."
50. Mr. and Mrs. Lee. Troubled expressions.
51. Graphic: same as #15, but this time TREATMENT PLANNING is highlighted.
52. Graphic illustration. People (on one side), buildings (on the other)
53. Same as #52, but now people are connected to buildings by lines or other graphic devices.
54. Graphic illustration. Large number of people. Large number of buildings—a few are highlighted.
55. Same graphic as #54—add lines connecting all the people to the few buildings.
56. A couple in family therapy. Their child is with

and friendship—

But good psychiatric resources exist and we're used to referring to them;

so we send them there rather than search for something more relevant to their needs . . .

Like a parents' group . . .

Participation in a day care center . . .

A foster grandparent program . . . in this case these could provide the kind of support and friendship the Lee family needs.

It's also important to assess the agencies you're considering very carefully—so you will have a realistic idea of what they can accomplish—and be able to choose which agency or service best meets your clients needs.

What kind of help does the agency offer? Does the staff have experience in working with child abuse cases? Can they handle the extra caseload?

Will the services offered meet the needs of your client? Will they accept referrals?

CPS WORKER: In the Lee case, we developed this treatment plan:

We recommended an excellent day care center for Jerry that had a strong parental involvement program.

While giving Jerry new opportunities for growth and awareness, we hoped it would introduce an important social element in his mother's life as well.

Both parents needed to improve communication between them, and needed to learn to get support from each other, so we selected a family counseling program at the Community Health Center.

Jerry's father definitely needed vocational guidance. So we recommended a training center we'd used before. Later, I realized we'd made a mistake there.

The center only offered guidance and training in fields *he* wasn't interested in.

Moreover, they weren't sensitive to how losing his job was affecting his feeling of self-worth.

He needed a more comprehensive vocational guidance service—and we don't have one in our town. You can't avoid making mistakes sometimes, but what's important is to keep asking the family *and* yourself—Does the treatment resource really fullfill their needs? Does the

them, playing with toys on the floor.

57. Therapist has his hand on the father's shoulder, is gesturing towards the wife. Parents don't have much expression.

58. Same family is leaving the building. Entry has "Community Mental Health Center" on it.

59. Parents' group.

60. Teacher helping child.

61. Older man and woman with child.

62. Building with large sign "Dept. of Public Social Services." People are going in and out.

63. Day care staff worker talking to Mr. & Mrs. Lee.

64. Entrance of building—a man is standing, talking to another man with his hand on a partially opened gate. Sign reads "Vocational Training Center."

65. Lee family portrait.

66. Jerry Lee and other children playing at day care center.

67. Mothers talking to each other at the day care center.

68. Mr. and Mrs. Lee.

69. Mr. Lee entering office Sign: "Vocational Guidance and Training Center."

70. CU: Mr. Lee disappointed.

71. Mr. Lee's POV—focus on vocational counselor.

72. Mr. Lee leaving the guidance agency.

73. CPS Worker in office—talking with Mr. Lee.

agency have the capability to work with the family successfully?

NARRATOR: After the treatment plan is completed, the next job is implementing it.

This process includes helping the family to acknowledge their need for treatment—

Checking out potential agencies to see if they are willing and able to provide services—

And then actually getting the family in contact with the agency and into treatment.

CPS WORKER Implementing the referral is always very hard for me . . .

You get a lot of resistance from families when you actually get to the point of referral.

You have to be as persuasive, supportive, and as clear as possible when explaining what the proposed treatment is all about, and how you see their problems and needs and how that determines treatment.

And, the *earlier* you can involve the family in the process, the better. If they can have a part, or be consulted in making decisions, they will accept the treatment plan more readily.

I always want to avoid taking a case into court if possible. I feel responsible to get them into treatment.

If they resist, it doesn't mean that we automatically go into court. It means that I need to work more with the family around why they're resisting—and I need to be aware of what *I do* that helps them, and what doesn't help them. After all, I could be wrong. You have to evaluate, too, who should initiate the referral. In some cases, it's important for the client to take the step of picking up the phone and making the contact.

Others may need you to make the contact and actually take them to the agency the first time or two.

The Lees were fairly cooperative. I think they were glad to be getting some help. I know Mr. Lee was probably deeply distressed by his child's injuries.

They agreed that the day care center would be a good idea and followed up on that themselves.

But Mr. Lee was suspicious about the idea of going into family counseling . . .

He believed the only people who needed counseling services were those who were really crazy.

I was ready to refer him anyway—because his wife was willing to try it. But that would have been a mistake.

74. Same graphic which introduces each section (from #15). IMPLEMENTING THE REFERREAL is highlighted.

75. CPS and Lee family.

76. Same CPS worker on phone.

77. Mr. & Mrs. Lee in therapy

78. MCU: Office. CPS worker concentrating on something.

79. MCU: CPS Worker talking, gesturing forcefully.

80. MS: Mr. Lee.

81. CPS Worker talking.

82. CPS Worker in conversation with the Lees.

83. CU: Client with hand on phone. Picking up receiver.

84. CPS Worker leading man and woman to car.

85. Mr. Lee observing Jerry at day care center.

86. Mr. and Mrs. Lee and Jerry being shown around the day care center.

87. CU: Mr. Lee—looks suspicious.

88. CU: Mr. Lee—expression of disgust.

89. CPS Worker, MR. & Mrs. Lee talking. Mr. Lee

Instead, I suggested group therapy at the same mental health center. He was still suspicious, . . . but I felt that when he saw the other people in the group were like him—with similar problems—he would become more receptive to treatment.

NARRATOR: Case monitoring involves the appointment of one person or team member to oversee the progress of the case and to make sure that treatment is effective.

It should begin as early in the referral process as possible, and continue until the family seems to have made satisfactory progress. If more than one agency is involved, the case manager can help coordinate treatment.

The case manager should also review the progress of the case periodically—perhaps by calling a case conference of all those involved.

Sometimes the treatment plan has to be changed if something isn't working out—or sometimes the case monitor can act as mediator if the family's having difficulty with the agency.

VOICE OF PHN: I took on the job of case monitor on the Lee case. I had known them for several years already and it would be easier for me to maintain regular contacts with them. While we've been following the Lee family. . . . . . I'm happy to say that Jerry has had no new injuries.

Mrs. Lee seems more outgoing and has made several friends through the day care center.

But we haven't been able to keep Mr. and Mrs. Lee in group therapy—they dropped out after four sessions.

I think I'm going to suggest a parent's group which is associated with the day care center. That might help.

NARRATOR: Not all cases are resolved as successfully as this one. Here a family stayed together—and are working with their problems.

When you are responsible for the diagnosis and referral of a case of child abuse and neglect—you can help the family and yourself by asking these questions:

What are the problems and needs of each member of the family? What's keeping them from caring for and protecting the child?

What kinds of referrals will meet the needs of the family? Who can provide it? Can they work successfully with your client?

How can you get the family to accept treatment? Who should initiate the referral?

Are the services effective? Are they meeting the family's needs?

Asking these kinds of questions may prove useful in helping you to make better referrals . . .

still has expression of suspicion and disgust.

90. CPS Worker gesturing, talking.

91. Group therapy scene.

92. The graphic which introduces each section (as in #15): CASE MONITORING is highlighted.

93. Snapshot of Lee family. (#17)

94. PHN, CPS Worker and doctor of Lee case in conference.

95. PHN talking on phone.

96. CU: Mrs. Lee at home, talking with PHN.

97. Jerry playing.

98. Mrs. Lee having coffee with a friend.

99. Mr. Lee, dejected, walking down street.

100. Parents' group. Same as #59.

101. Mr. Lee and Jerry.

102. Split Screen: A number of different "professionals" ones we've seen already in the program. (CPS, PHN, & DR.)

103. Lee Family.
Super: NEEDS ASSESSMENT

104. Photo #40 repeated.
Super: TREATMENT PLANNING

105. CPS Worker, Mr. & Mrs. Lee.
Super: INITIATING THE REFERRAL.

106. Shot of group of professionals.
Super: CASE MONITORING

107. Split screen: Of CPS & Mr. Lee and Lee family.

Referrals that can help the family

108. Mr. & Mrs. Lee—sympathetic expressions. They are touching.

And protect the child.

109. Lee family portrait.

CREDITS

END

Unit 7: THE ROLE OF THE COURTS IN CHILD ABUSE AND NEGLECT

UNIT 7.

Time: 1 hour 30 min.
(plus optional 1 hour)

THE ROLE OF THE COURTS IN CHILD ABUSE AND NEGLECT

DESCRIPTION OF UNIT:

This unit provides an overview of the role of the courts in the child protective process. It contains: (1) a presentation that describes and contrasts criminal and juvenile court proceedings as they relate to cases of child maltreatment; and (2) an "interview" with an attorney or juvenile court judge familiar with local juvenile court proceedings. A third, optional activity uses a film, entitled "Medical Witness," to portray a professional involved in a juvenile court adjudicatory hearing and to help participants begin to define their possible roles as witnesses in such proceedings.

GOALS:

1. To provide participants with information on the different purposes, authority, and procedures of criminal and juvenile courts in cases of child abuse and neglect.
2. To allow participants an opportunity to define the roles and responsibilities of the various legal professionals involved in juvenile court proceedings.
3. To provide participants with knowledge about their own local juvenile court and the way it handles child protective petitions.
4. To provide participants with definitions of legal terms used in child abuse and neglect cases.

OBJECTIVES:

At the conclusion of this unit, participants will be able to:

1. Describe two differences in the approaches of criminal and juvenile courts to the handling of child abuse and neglect cases.
2. List four procedural stages of juvenile court cases of child abuse and neglect.
3. List four possible participants in juvenile court cases of child abuse and neglect.
4. Describe the relationship of the local juvenile court and the local child protection agency.
5. List those professionals or agencies with legal authority to place children in temporary protective custody pending juvenile court authorization.

RATIONALE:

This unit deals with an aspect of the child protective process that is most personally threatening or most frustrating to many nonlegal professionals. In large part, such fears and frustrations stem from a simple lack of information. Thus, this unit should be presented clearly and factually. Another reason for problems on the part of social workers and educational and medical professionals with the courts may be a lack of communication. By inviting a local juvenile court judge (if possible) or an attorney with local juvenile court case experience to present relevant local information, the leader can help to build some new bridges of communication between the community's front line child protection network (i.e., the session's participants) and the court, which often will have to impose its authority to insure that children are provided with safety from abuse and neglect.

ADDITIONAL STAFF NEEDED:

Guest Interviewee who should be a local juvenile court judge or attorney with local juvenile court case experience.

SPACE REQUIREMENTS:

One room large enough to accommodate the total group.

EQUIPMENT:

Optional Activity:
35 mm. sound projector
Screen
Extension cord and adapter plus, if necessary

AUDIOVISUALS:

Optional Activity:
Film: *"The Medical Witness"*

BEFORE YOU BEGIN:

Duplicate sufficient copies of the "Glossary of Selected Legal Terms in Child Abuse and Neglect," unless each participant has a copy of **WE CAN HELP Resource Materials.** Be sure to invite the guest judge or attorney several weeks in advance of the training session, and remind him/her within a week beforehand. Provide the guest with the list of questions that will be asked in the interview (See Activity 3).

If you decide to include the optional film and discussion in this unit, be sure to preview it beforehand. Pick out the key points and use them to introduce the film and to lead the follow-up discussion.

PARTICIPANTS' MATERIALS

Resource Paper: *"Overview of the Role of the Courts in Child Abuse and Neglect"*

"Glossary of Selected Legal Terms in Child Abuse and Neglect"

ACTIVITY	TIME	MATERIALS
1. Leader Presentation: "Overview of the Role of Courts in Child Abuse and Neglect"	20 minutes	Resource Paper: "Overview of the Role of Courts in Child Abuse and Neglect"
2. Group discussion: "Understanding the Role of the Courts"	20 minutes	
3. Guest Interview: "The Local Juvenile Court and Its Procedures"	30 minutes	
OPTIONAL BREAK	10 minutes	
4. OPTIONAL: Film and Discussion	60 minutes	Film: "The Medical Witness"
5. Summary	10 minutes	Glossary of Selected Legal Terms in Child Abuse and Neglect

ACTIVITIES

ACTIVITY 1. LEADER PRESENTATION: "Overview of the Role of the Courts in Child Abuse and Neglect"

20 minutes

Resource Paper: "Overview of the Role of the Courts in Child Abuse and Neglect"

The content for this presentation is contained in the resource paper which has the same title as this presentation. It is located on page 91 of the **WE CAN HELP Resource Materials.** If participants have had an opportunity to read this paper prior to the session, the presentation can serve as a review. If not, participants should be asked to follow the points made in the presentation with the paper as a set of ready-made notes. Participants may be encouraged to ask questions if they need clarification.

How courts fit into child protective process

Courts—both criminal and juvenile—provide necessary authority in many cases of child abuse and neglect. When a report has been made and an initial investigation has substantiated that a child has been abused or neglected or is in imminent danger of harm, the power of a court may be required to take the necessary protective action. The seriousness of the child's circumstances may suggest the need for court authority to give sanction to a treatment plan for parents and the child, when such a treatment plan is not voluntarily accepted. Only in rare situations will criminal prosecution and punishment be warranted as a result of parents' abusive behavior toward a child.

Two types of courts

There are two types of courts which may be involved:

Criminal court

> **Criminal court,** as provided either by laws making child abuse and neglect a crime or under general criminal statutes dealing with assault, battery and rape.

Juvenile court

> **Juvenile court,** which handles civil cases involving minors, including delinquency, status offenses (children in need of supervision, runaways) child abuse and neglect, and dependency.

Functions of criminal courts

Criminal courts have these basic functions:

1. To determine the guilt or innocence of the accused.
2. If the accused is found guilty, to determine appropriate sentencing.
3. To mandate social or other services (as terms of probation).
4. To protect the constitutional rights of the accused.

Criminal court authority

Criminal courts have authority over *defendants*, including those brought before them accused of child maltreatment. They have no authority to make orders concerning the child victims. On finding a defendant guilty, they may fine or imprison, or they may place on probation, usually with a condition that defendants do certain things to change the circumstances which have led to the guilty verdict.

Criminal court procedures

Criminal court procedures usually involve these steps:

1. Arrest by the police and referral of the case to the county (or district) prosecutor.
2. Decision by the prosecutor to indict. (Or it may be the decision of a grand jury.)
3. Prosecution in court, where the defendant is entitled to be represented by an attorney and to a trial by jury.

A criminal prosecution of child abuse to determine the guilt or innocence of the alleged perpetrator may proceed at the same time as a juvenile court proceeding to determine the necessity for taking protective action on behalf of the child.

Juvenile court focus

Juvenile courts do not focus primarily on the guilt or innocence of the perpetrator of abuse or neglect. Their initial concern is to determine whether the child's condition or circumstances as described by the petition can be sustained by the evidence presented. Only after the allegations are sustained can the court act to protect, treat or otherwise intervene into the life of the child or family.

Juvenile court functions

Juvenile court functions include:

1. Screening and referral of complaints from all sources (by court intake units):
    - Referring complaints of alleged abuse or neglect to the appropriate community agencies when there is not sufficient evidence to file a petition.
    - Authorizing the filing of petitions (in cooperation with the prosecutor's office).
    - Dismissing complaints in situations over which the court has no jurisdiction (e.g. the "child" is over the age of court jurisdiction.
2. Protecting children from further injury.
3. Mandating services to families where abuse or neglect has occurred. (The court may endorse or perhaps even cooperate with child protective agency recommendations of treatment plans for families.)
4. Providing fair and impartial review of child protection agency decisions (for example, a decision that abuse has occurred).
5. Protecting the constitutional rights of parents and children.

Juvenile courts have jurisdiction over minors. They can determine that a child's home is not safe and make these kinds of orders:

- Order the child placed in its home, under the supervision of the juvenile court probation department or the department of social services.
- As above, with the further order that the parent(s) obtain counseling, or other social services.
- Order the child placed with relatives, if there are relatives able and willing to care for the child.

- Order the child placed in a foster home, group home, or institutional home.

Juvenile court authority

- In some States, the juvenile court has the authority to terminate the rights of the parent(s). Such an order completely and permanently cuts off all rights of the natural parent to the child and is a prerequisite to adoption of the child. Usually, such an order follows serious, often repeated incidents of physical or sexual abuse, or the abandonment of a child by the parent(s). In some States a termination proceeding must be brought in another division of the district or county court.

Juvenile court procedures
The petition

Juvenile court procedures involve these steps:

1. *The petition.* A juvenile court child abuse and neglect case can be initiated by the filing of a petition (written complaint) in the juvenile court alleging that a certain child (or children) has been abused or neglected. According to State law and local court procedures, the petition may be written and filed by the county attorney, the juvenile probation officer and/or a child protective service worker. In a few States, *anyone* can file a petition alleging that a child is abused or neglected.

Custody hearing

2. *Custody hearing.* In emergency situations where there is imminent danger to the child if the child were to remain with the parent(s), the child may be removed from the custody of the parent(s) and placed in protective custody pending the outcome of a juvenile court proceeding. This decision may be made by the police, juvenile probation, the juvenile court, child protective services and/or a physician, depending on State laws. Whenever a child is placed in protective custody, a petition must be filed in the juvenile court, usually within 24 to 48 hours, and a hearing must be held soon thereafter (usually within 48 to 72 hours, depending on State law) to allow a judge or commissioner to review the decision to place the child in protective custody. The judge may decide to continue the order for custody pending the adjudicatory hearing or may decide to terminate it.

3. *Adjudicatory (adjudication) hearing.* This is the evidentiary trial in which the State must prove to a judge that the child is abused or neglected. Unless the parent(s) admits that he/she has neglected or abused the child, it will be necessary to call witnesses to substantiate the allegations of abuse or neglect.

Adjudicatory hearing

   The adjudicatory hearing usually occurs from 2 to 6 weeks after the initial petition is filed. Because a dependency hearing is civil rather than criminal, the State need not prove abuse or neglect beyond a reasonable doubt, but only by a preponderance of the evidence, a somewhat lower standard of proof.

Dispositional hearing

4. *Dispositional hearing.* Child abuse and neglect proceedings in the juvenile court are "bifurcated proceedings," meaning the decision as to what should

be done with the abused or neglected child occurs in a separate hearing from that which determines whether the child is, in fact, abused or neglected. A dispositional hearing may occur on the same day as the adjudicatory hearing or may be held on a separate day, sometimes weeks later. The evidence presented at the dispositional hearing focuses on the ability of the family to care for the child and on the recommendation of the court social worker as to the appropriate placement for the child. Hearsay and opinion evidence which might not be admitted at the adjudicatory hearing will usually be admitted during the dispositional hearing.

Periodic reviews

5. *Periodic reviews.* In some States, no review hearings are held. In others, they are an integral part of the hearing process. If a child has been declared dependent, the juvenile court retains jurisdiction over that child until the child reaches adulthood or until the dependency status is ended by the juvenile court. In order to measure the progress of the case and determine any need to modify its previous order, the juvenile court will schedule a review hearing on the case some months after the dispositional hearing. At that time, the child might be returned home and the case dismissed; the court may retain jurisdiction of the case for still another year, or the child might be placed for adoption after parental rights have been terminated. Additionally, the petitioner or the parents may request modification hearings at any time.

20 minutes

ACTIVITY 2. GROUP DISCUSSION: "Understanding the Role of the Courts"

This discussion guide is designed to help the leader facilitate exploration of attitudes about key issues in the approach of the courts to child abuse and neglect. While the presentation in Activity 1 concentrates on basic, objective information about the court process, the discussion gives participants an opportunity to express their feelings about the court process and to increase their awareness of current issues in the role of the court in child abuse and neglect.

Discussion Area #1.

Appropriateness of criminal prosecution for child abuse and neglect.

Questions

1. Should an individual accused of abuse or neglect be criminally prosecuted?
2. If yes, under what circumstances? Why?
3. If no, why not?

Background

The use of the criminal courts in child abuse and neglect cases is controversial. Most professionals feel that child abuse and neglect is a psychosocial problem which should be handled by a social services approach. Others argue that an individual who abuses or neglects a child has committed a crime and should be treated as any other criminal, that is, prosecuted.

Some typical arguments which may be given for and against the social services approach are provided to help the trainer facilitate this discussion. The statements are representative of the types of opinions held by some professionals in the field, and are not presented as factual statements about the handling of child abuse and neglect cases.

Reasons Cited For Criminal Prosecution

1. Child abuse and neglect are crimes and should be treated like all other crimes.
2. Criminal prosecution and conviction of child abusers will deter the individual defendant and others from acts of abuse or neglect.
3. Criminal prosecution and conviction is necessary to bring about meaningful change in the behavior of the abuser, since the criminal court has the power to enforce its order by requiring the abuser to participate in social service programs.
4. Unless criminal prosecution results from police involvement in child abuse and neglect cases, the police will not be willing to act in such cases.
5. Criminal prosecution affords the defendant full due process rights and forces the State to prove abuse or neglect beyond a reasonable doubt. Because of this, the family's right of privacy is better protected than when the intervention into the family occurs through juvenile court or a social service agency.

Reasons Cited Against Criminal Prosecution

1. Child abuse and neglect are psychosocial problems which should be handled by a nonpunitive social service approach designed to preserve the family structure, as well as to protect the child.
2. Child abusers often see themselves as victims, as people who are helpless and isolated from the social mainstream. Prosecution and conviction, especially if it leads to incarceration, may tend to reinforce these feelings and may lead to increased hostility and resentment. These feelings may in turn lead to further abusive acts.
3. Criminal prosecution and conviction is more likely to break up the family than are other approaches to the problem.
4. Because successful criminal prosecution of child abuse is very difficult, due to the high standard of proof required and the fact that there are often no witnesses other than the child victim who is too young or frightened to testify, many prosecutions result in dismissal or acquittal. Some professionals argue

that in such instances, even though it may be clear that the child is receiving inadequate care, the exonerated defendant will be unwilling to participate in any social service programs. (It should be pointed out that dismissal or acquittal may be the result of lack of abuse rather than lack of evidence.)

5. In cases which involve both juvenile and criminal court proceedings it is possible that the decision of one court will undermine that of the other. To avoid this situation, juvenile courts at times have a tendency to adopt a "wait and see" attitude, in which the decision on placement of the child will be delayed until the criminal court case is concluded.

Discussion Area #2.

Appropriateness of the juvenile court in cases of child abuse and neglect.

Question

Does the juvenile court play a positive or negative role in child abuse and neglect cases?

Background

Although the juvenile court is designed to be a social service oriented branch of the court, it has received criticism from many professionals involved with child abuse and neglect cases.

Some typical arguments which may be given for and against the juvenile court's involvement in child abuse and neglect cases are provided to help the leader facilitate this discussion. The statements are representative of the types of opinions held by some professionals in the field, and are not presented as factual statements about the juvenile court's role in child abuse and neglect cases.

Reasons Cited For Juvenile Court Involvement

1. The juvenile court provides a coercive but nonpunitive authority to function in cooperation with social service agencies.
2. The juvenile court guarantees some due process rights of parents and children and allows for independent review of discretionary decisions by social service agencies, particularly decisions to remove the child from the home.
3. The juvenile court has the power to mandate and monitor social and protective services for families. In some situations, eligibility for certain social services is conditioned upon the child being declared a dependent of the court.

Reasons Cited Against Juvenile Court Involvement

1. Court proceedings and the roles of the attorneys increase the level of conflict among all parties involved and reduce the potential for cooperation by the family with social service agencies.
2. Juvenile court intervention is too authoritarian and traumatic for the family. The court should be used only as a last resort if social service agency efforts fail.
3. The juvenile court is too involved in technical rules of procedure and evidence. This preoccupation often obscures the true nature of a case and may lead to a lack of perception of the risk to a child.

Discussion Area #3.

The role of juvenile court judges.

Question

What factors most affect the ability of the juvenile court judge to effectively handle child abuse and neglect cases?

Background

The role of the juvenile court judge in a child abuse and neglect case is a difficult one. As described in the lecture, the judge must: 1) ensure that all rules of evidence and procedure are followed, 2) decide on the basis of the evidence presented whether or not abuse or neglect has occurred, and 3) decide on the appropriate disposition of an abused or neglected child. In addition, although juvenile court responsibilities are so great, being a juvenile court judge has low status position among judges. Many prefer the prestige of the criminal branch or other civil branches of the county court.

Discuss the attitudes of the participants toward the juvenile court judge's role in child abuse and neglect cases. In discussing these attitudes, consider some of the factors which make the judge's role in child abuse and neglect cases a difficult one. Among those factors, consider the following:

1. Lack of training and expertise in child abuse and neglect cases.
2. Difficulty of monitoring child abuse and neglect cases after the dispositional

hearing, and the difficulty of ensuring the delivery of social and other services to the family.

3. Problems of communication and cooperation with the local social services department.
4. Heavy caseload in juvenile court, preventing the judge from taking the time necessary to consider a child abuse and neglect case.
5. Poor appointments of judges to the juvenile court system.
6. Inadequate support staffs to assist the juvenile court judge.
7. Difficulty of strictly enforcing legal standards and procedures while also assisting troubled families in an informal and nonpunitive manner.
8. Lack of adequate social and other services in the community to work with child abuse and neglect cases.
9. Difficulty of deciding when "best interest of child" requires child to be removed from the natural family, temporarily or permanently.

Discussion Area #4.

The role of attorneys for the petitioner in child abuse and neglect cases (juvenile court).

Question

What factors affect the ability of the attorney for the petitioner to effectively present child abuse and neglect cases in juvenile court?

Background

The attorneys representing the petitioner in a child abuse and neglect case must present sufficient evidence to the judge to prove that a child is abused or neglected. Because of this role, they must focus on available, detailed, factual information to prove the case. This concern for detail and for specific admissible evidence often creates resentment among the witnesses called to testify. This same concern often creates hostility between the county attorney and the representative of the petitioning agency.

The leader should explore with the participants the differences in roles played by the attorney and by child care professionals which might create this hostility; for example, the attorney's need for details and evidence vs. the petitioner's need for subjective types of information indicating family dysfunction and individual psychological needs. Given these different needs, a child protective worker, concerned with broad areas of family dysfunction, may resent the attorney's seemingly irrelevant concern for details while the attorney may resent the worker's "fuzziness" and lack of concern for specific detailed information. Some factors affecting the ability of the county attorney to effectively present child abuse and neglect cases in juvenile court include:

1. Lack of training or experience in child abuse and neglect cases.
2. Unclear relationship between county attorney and agency which requested the petition. This may arise when the county attorney "settles" the case in conference with the judge and attorney for parents without agreement from the social service agency which requested petition.
3. Lack of adequate preparation time prior to court hearing because of heavy caseload, or lack of interest.
4. Inability of attorney to present the case in court because of lack of specific evidence.
5. Need of attorney to "win" the case for professional career reasons.
6. Attorney's lack of knowledge about psychosocial dynamics of child abuse and neglect.
7. Poor preparation.

Discussion Area #5.

Role of the attorneys for the parent in child abuse and neglect cases (juvenile court).

Question

What factors affect the ability of attorneys for the parents to effectively represent their clients?

Background

Many child care professionals resent the role played by the attorney whose job it is to represent the interests of the parents at a child abuse and neglect hearing. Sometimes the resentment derives from the refusal of the parents' attorney to advise his or her client(s) to admit the allegations of the petition and accept social services without a full hearing; or from the fact that he or she may subject witnesses to intense cross-examination and may vigorously oppose a social service department's recommendation for placement. It should be noted that, in many ways, the attorney for the parents has the antagonist's role in child abuse and neglect proceedings—a position which may influence the participants' feelings.

In some cases, the attorney for the parent(s) may feel a personal and professional dilemma because he/she may have reason to believe his/her clients have, in fact, abused or neglected a child. In such cases, the attorney's feelings toward the abused or neglected child may conflict with his/her feelings, and professional responsibility, toward the parents. Some attorneys in this situation urge their clients to voluntarily accept social services. However, if the parent(s) insist on going to court, the attorney may be caught between a professional responsibility to provide the best possible representation for his/her client and a belief that a successful defense would result in further danger to a child. Other factors affecting the role of the attorney for the parent(s) include:

1. Many attorneys are concerned only with winning the case, not with helping the family or protecting the child. This may cause the attorney to be concerned only with trial strategies and legal technicalities, and to lose sight of the best interests of the child and, ultimately, his/her clients.
2. Some attorneys are criticized because their vigorous defense of the clients increases the parent(s) hostility toward social service departments, and frustrates social service efforts to help the family.
3. Lack of adequate preparation for court hearing due to heavy caseload.
4. Lack of experience and expertise in child abuse and neglect cases.
5. Too interested in money which makes them want to take every case to court, whether or not this is in the best interests of the families.

ACTIVITY 3. *Guest Interview*

30 minutes

Set-up for interview

If possible, the front of the room should be arranged so that the leader (interviewer) and the guest can sit next to each other and converse comfortably while allowing the participants to hear questions and answers (much like a "talk show"). The leader uses the following script, which has been shared with the guest in advance. In order to ensure that all the material is covered, it is recommended that participants be asked to hold their questions and comments until the end of the interview.

Introduce guest and beginning interview.

The leader introduces the guest and begins asking questions for the guest to answer, based on local juvenile court procedures and practice.

1. In which civil court are abuse and neglect petitions filed? Where is the court located? What are its general functions? What are its specific functions in abuse and neglect cases?
2. Are there judges/referees/masters? Who are they? How are they chosen? How long are their terms in this court? What training or experience do they have in child abuse and neglect cases? Is there a "child abuse and neglect branch" of the court?
3. How does a case initially get into the court? What agency files the petition? Which individuals? Is a "county attorney" involved? Who refers cases to the petitioning agency? How?
4. Describe the social and child protective services provided by or available to the juvenile court. Describe the relationship between the court and the juvenile court probation department, county social services agencies, and any local child abuse and neglect councils or other child abuse and neglect consortiums.
5. Describe the role of the court intake worker in connection with abuse and neglect cases.
6. What must the petition allege in an abuse or neglect case?
7. What is the law regarding emergency protective custody of a child? How and when is protective custody (pre-trial detention) reviewed by the court? Describe the protective custody hearing. Are attorneys present? Witnesses?
8. Where might the child be detained? Describe the detention facilities.
9. Describe the role of the various attorneys who may be involved in a child abuse and neglect case in civil court. Who represents the petitioner? Is there an attorney appointed for the parents? The child? A guardian *ad litem* for the child?
10. Describe the adjudication hearing. What happens? When? Formal or informal? Do witnesses spend much time waiting for the case to be called? Are there ways to avoid this? Are there attorneys available to consult with the witnesses about their testimony?

11. Describe the plea-bargaining process and state how, if at all, it applies to child abuse and neglect cases in your community.
12. Describe the disposition hearing and the possible dispositional orders in an abuse or neglect case. When is it held? Are there witnesses? Who? Include information about the social report prepared for the disposition hearing. Who prepares it? How? Does the court always follow the recommendation?
13. Who supervises the case after the disposition hearing? Are many cases "lost" after the court process (i.e., parents don't follow through on "treatment," child is shuffled from foster home to foster home, etc.)?
14. Describe the process by which court orders are reviewed for subsequent modification. Is a review automatic after a certain period of time? Six months? One year? How is a case terminated?
15. How are parental rights terminated? Can this be done by the court in its disposition order, or must there be a separate proceeding? In another court? What evidence must be presented before the court will terminate parental rights?
16. What kinds of abuse and neglect cases are being criminally prosecuted in our county? What kinds of sentences are being given?

ACTIVITY 4. (OPTIONAL) FILM AND DISCUSSION.

60 minutes

Introduce film (3 minutes)

This film, "The Medical Witness," was prepared as a part of the *WE CAN HELP* curriculum unit for medical and health professionals. It dramatizes the involvement of a pediatrician in preparing for and serving in court as an "expert witness" in a child abuse hearing.

The leader should ask participants to watch for the different parts of the preparation and testimony, including:

- Pre-court preparation with the county attorney,
- Establishing the witness as an expert,
- Direct examination on the case by the county attorney, and
- Cross-examination by the defense attorney.

FILM

Show film (35 minutes)

Discussion:

Discuss film (22 minutes)

The follow-up discussion should draw out the learning points of this film, with special attention to those common to any professional witnesses in child abuse and neglect proceedings in juvenile courts. A guide which provides an outline to the points covered in the film is included in the leader's materials for this unit on page 249.

SUMMARY

10 minutes
Point out Glossary
Use objectives as summary discussion questions

To summarize this unit, the leader may point out the Glossary in the **WE CAN HELP Resource Materials**, page 96, or hand out copies, if participants do not have it. Then the leader may use the objectives for this unit as a group participation summary that will underline some of the unit's most important points.

1. What are the differences in the approaches of criminal and juvenile court handling of child abuse and neglect cases?
2. What are some of the procedural stages of juvenile court handling of cases?
3. Who are some of the possible participants in a juvenile court case involving child maltreatment?
4. What is the relationship between the local juvenile court and the local child protection agency?
5. Which professionals and agencies have legal authority to place children in temporary protective custody pending juvenile court authorization?

OVERVIEW OF THE ROLE OF THE COURTS IN CHILD ABUSE AND NEGLECT

This paper provides a summary description of the criminal and juvenile court laws governing child abuse and neglect and examines in some detail the purpose, jurisdiction and procedure of criminal and juvenile courts with respect to child abuse and neglect cases.

CRIMINAL LAWS

Laws which make it a crime to abuse or neglect a child. Some States have criminal laws specifically dealing with child abuse and neglect. In other States, prosecutions for child abuse and neglect are brought under general criminal statutes such as assault, battery or rape.

JUVENILE COURT LAWS

Laws which set forth the authority of juvenile courts to act in cases involving minors. These cases are of three types: delinquency, status offenses (children in need of supervision, runaways), and child abuse and neglect (dependency). Provisions of the juvenile court laws set forth the procedures to be followed in child abuse and neglect cases. In addition, they usually contain definitions of child abuse and neglect for purposes of juvenile court jurisdiction.

Child abuse and neglect cases are often called dependency cases because of the juvenile court's power to declare abused and neglected children "dependent" on the court for proper care and protection. Most cases of child abuse and neglect are referred to the juvenile court rather than to the criminal court.

THE ROLE OF THE CRIMINAL COURTS IN CHILD ABUSE AND NEGLECT

Functions

1. To determine the guilt or innocence of the accused.
2. If the accused is found guilty, to determine appropriate sentencing.
3. To mandate social or other services (as terms of probation).
4. To protect the constitutional rights of parents.

Authority

1. Criminal courts have jurisdiction over the defendant, that is, the adult accused of abuse or neglect. The court in a criminal proceeding has no authority to make orders concerning the child victim.
2. The court may fine or imprison a defendant convicted of abuse or neglect. The court may also place the defendant on probation, allowing the individual to go free, but under the supervision of a probation officer. Often, probation is granted only on the condition that the defendant does certain things such as seek employment or obtain counseling and refrains from the original abuse.

Procedures

1. Criminal prosecutions are initiated by the police, who may arrest the defendant and refer the case to the county prosecutor. In most cases, the prosecutor's office makes a separate, discretionary decision as to whether the case will be prosecuted. In some instances, the case will be presented by the prosecutor to the grand jury, and it will decide whether to indict (file criminal charges against) the defendant. It may reject the case and/or refer it to the juvenile court. In some instances, criminal prosecution of the alleged abuser may proceed at the same time as a juvenile court action on behalf of the child victim.
2. Criminal prosecutions of child abuse and neglect cases are handled in the same manner as other criminal prosecutions. The defendant is entitled to an attorney and to a jury trial if requested.

THE ROLE OF THE JUVENILE COURTS IN CHILD ABUSE AND NEGLECT

Philosophy of Juvenile Court

The juvenile court approach to cases of child abuse and neglect focuses on the child's need for protection from physical or psychological harm caused by abusive or neglectful parents and the parents' need for social and other services to improve their ability to care for the child. This focus requires the court to work closely with social service professionals in determining the appropriate court response to cases in which abuse or neglect has been proven. Law enforcement officers must understand that the juvenile court will attempt to handle child abuse and neglect cases in a social services fashion, if possible, and will try to avoid placing the child outside the home on a permanent basis or terminating the parental rights of the natural mother and/or father. More often, the court disposes of proven cases of abuse and neglect by either sending the child home under the supervision of the social services agency or probation department or by ordering the child placed out of the home on a temporary basis until the parent(s) are better able to provide care. Only when the parent(s)' unwillingness or inability to care for the child continues over a long period will the juvenile court take necessary steps to terminate the parental rights and place the child for adoption.

Functions of Juvenile Court

The juvenile court performs a variety of functions in connection with child abuse and neglect cases brought before it. The most important of these are:

1. To mandate services for the family in which abuse or neglect has occurred. Rather than punish, the juvenile court will work closely with social service agencies to effect a treatment plan designed to protect the child and, at the same time, improve the family situation so that the family is preserved.
2. To protect a child from further injury as a result of abuse or neglect.
3. To provide a fair and impartial review of social service agency decisions.
4. To protect the constitutional rights of parents and children.

Authority of the Juvenile Court

The juvenile court has jurisdiction over minors. The court is primarily involved in three types of cases—delinquency, status offenses and child abuse and neglect. If the court takes jurisdiction over an abused or neglected child, it has authority to make several types of orders concerning the physical custody of the child:

- Order the child placed in his/her home, under the supervision of the juvenile court probation department, or the child protection agency.
- As above, with the further order that the parent(s) obtain counseling, or other social services.
- Order the child placed with relatives, if there are relatives able and willing to care for the child.
- Order the child placed in a foster home, group home, or institutional home.
- In some States, the juvenile court has the authority to terminate parental rights. Such an order completely and permanently cuts off all rights of the natural parent to the child and is a prerequisite to adoption of the child. Usually, such an order follows serious, often repeated incidents of physical or sexual abuse, or the abandonment of a child by the parent(s). In some States a termination proceeding must be brought in another division of the district or county court.

Juvenile Court Procedures: Overview of Hearing Process

It is the responsibility of the juvenile court to insure that the legal rights of parents and child are protected. It must assure that no government intervention into the life of the family occurs without due process of law and without the opportunity for both parents and child to have a fair and impartial hearing in a court of law. This function has led to increasing formality and stricter adherence to rules of evidence and procedure in the juvenile court. It has also led to the increased role of attorneys in abuse and neglect cases.

1. **The petition.** A juvenile court child abuse and neglect case can be initiated by the filing of a petition (written complaint) in the juvenile court alleging that a certain child (or children) has been abused or neglected. According to State law and local court procedures, the petition may be written and filed by the county attorney, the juvenile probation officer and/or a child protective service worker. In a few States, *anyone*

can file a petition alleging that a child is abused or neglected.

2. **Custody hearing.** In emergency situations where there is imminent danger to the child if the child were to remain with the parent(s), the child may be removed from the custody of the parent(s) and placed in protective custody pending the outcome of a juvenile court proceeding. This decision may be made by the police, juvenile probation, the juvenile court, child protective services and/or a physician, depending on State laws. Whenever a child is placed in protective custody, a petition must be filed in the juvenile court, usually within 24 to 48 hours, and a hearing must be held soon thereafter (usually within 48 to 72 hours, depending on State law) to allow a judge or commissioner to review the decision to place the child in protective custody. The judge may decide to continue the order for custody pending the adjudicatory hearing or may decide to terminate it.
3. **Adjudicatory (adjudication) hearing.** This is the evidentiary trial in which the State must prove to a judge that the child is abused or neglected. Unless the parent(s) admits that he/she has neglected or abused the child, it will be necessary to call witnesses to substantiate the allegations of abuse or neglect.

   The adjudicatory hearing usually occurs from two to six weeks after the initial petition is filed. Because a dependency hearing is *civil* rather than *criminal* the State need not prove abuse or neglect beyond a reasonable doubt, but only by a preponderance of the evidence, a somewhat lower standard of proof.
4. **Dispositional hearing.** Child abuse and neglect proceedings in the juvenile court are "bifurcated proceedings," meaning the decision as to what should be done with the abused or neglected child occurs in a separate hearing from that which determines whether the child is, in fact, abused or neglected. A dispositional hearing may occur on the same day as the adjudicatory hearing or may be held on a separate day, sometimes weeks later. The evidence presented at the dispositional hearing focuses on the ability of the family to care for the child and on the recommendation of the court social worker as to the appropriate placement for the child. Hearsay and opinion evidence which might not be admitted at the adjudicatory hearing will usually be admitted during the dispositional hearing.
5. **Periodic reviews.** In some States, no review hearings will be held. In others, they will be an integral part of the hearing process. If a child has been declared dependent, the juvenile court retains jurisdiction over that child until the dependency status is ended by the juvenile court or until the child reaches adulthood. In order to measure the progress of the case and determine any need to modify its previous order, the juvenile court will schedule a review hearing on the case some months after the dispositional hearing. At that time, the child might be returned home and the case dismissed; the court may retain jurisdiction of the case for still another year, or the child might be placed for adoption after parental rights have been terminated. Additionally, the petitioner or the parents may request modification hearings at any time.

Participants in the Juvenile Court Process

1. **Juvenile Court Intake Unit**
   a. Intake units screen and refer complaints that are referred to the juvenile court from all sources.
   b. Child Protective Services may "bypass" the intake unit to file a petition directly.
   c. Referrals by the intake unit can include the referral of complaints to community agencies when it is obvious that there is insufficient evidence to file a petition.
   d. The Intake Unit may authorize the filing of a petition (with the cooperation of the prosecutor's office).
   e. The Intake unit may dismiss complaints in situations over which the court has no jurisdiction (e.g., the "child" is beyond the age jurisdiction of juvenile court).
2. **Judge**
   a. Many child abuse and neglect cases in juvenile court are heard by judges assigned on a rotating basis to a term in the juvenile court.
   b. Some judges with special interest in juvenile court stay in that court for longer periods than their as-

signed term, thereby gaining experience and expertise in the child abuse and neglect area.

c. In some counties, juvenile court commissioners, masters, or referees are used in place of judges. They are usually attorneys appointed full- or part-time to hear cases only in juvenile court.

d. There is no Federal constitutional right to a jury in a child abuse and neglect case in juvenile court. Based on their State constitution, some States allow a jury trial in child abuse and neglect cases, but as of the mid-1970's, juries are very seldom used in child abuse and neglect cases in juvenile court.

e. The judge is responsible for assuring that fair and proper court procedures are observed at all times.

f. The judge must also decide, *based on the evidence presented during the hearing*, whether the child is abused or neglected.

g. The judge is also responsible for determining the appropriate placement for the child and for modifying the placement order as necessary.

3. **County Attorney** (District Attorney, Corporation Counsel, City Attorney, County Counsel, Attorney General, etc.)

a. In most juvenile courts, there will be a county attorney whose job is to present the child abuse or neglect case to the court. Some child welfare agencies have their own attorney to represent them in court. In most counties, however, this job is performed by an attorney in one of the county law agencies. In some counties, social workers or probation officers present the case in court without the assistance of an attorney (The National Center on Child Abuse and Neglect strongly recommends that an attorney be required to present child abuse and neglect cases in the juvenile court).

b. The county attorney presents evidence which will prove that the child is abused or neglected. He/she carries the burden of proving abuse or neglect by a preponderance of the evidence (or, in some states, by clear and convincing evidence).

4. **Attorney for the Parents**

a. In every State parents have the right to be represented by their own attorney in a child abuse and neglect case in juvenile court. Not every State however, will appoint an attorney for the parents if the parents are indigent. The National Center on Child Abuse and Neglect strongly recommends that parents be represented by counsel because of the seriousness of such cases. In some cases, legal aid attorneys or public defenders are filling this role.

b. The attorney for the parents represents the interests of the parents, which often involves an attempt to defend against the allegations of abuse or neglect at the adjudicatory hearing.

c. At the dispositional hearing the attorney for the parents will represent the interests of the parents particularly in connection with issues involving placement of the child.

5. **Attorney for the Child**

a. In some cases of child abuse and neglect, an attorney is appointed for the child. When this occurs, there are usually at least three attorneys involved in a child abuse and neglect hearing—the attorney for the State, the parents' attorney, and the child's attorney.

b. The child's attorney tries to represent the best interests of the child. If the child is old enough to communicate intelligently with the attorney, the attorney for the child is responsible for making sure the child's views are heard.

c. The attorney for the child may present separate evidence and argument at the adjudicatory hearing and may assist either the petitioner's attorney or the the parents' attorney, according to the wishes or best interests of the child.

d. The child's attorney may play a key role at the dispositional hearing in presenting a plan for the child's future placement.

e. The Federal Child Abuse Prevention and Treatment Act of 1974 requires that a State appoint a guardian *ad litem* ("in a lawsuit") for a child in a child abuse and neglect proceeding if that State is to be eligible for Federal funds for child abuse and neglect programs. The act does not specify that the guardian must be an attorney. (See Glossary of Selected Legal Terms)

6. **The Witnesses**

   These may include the petitioner, child protective services, probation officers, police, social workers, physicians, teachers, nurses, relatives, the child, the parents and any other individuals having relevant information. In many child abuse and neglect cases, subpoenas will be issued to compel the attendance of witnesses at the adjudicatory hearing. The attendance of witnesses at the dispositional hearing is less common and is usually limited to the court probation officer or a child protective service worker, the parents, the child, the family's social worker if there is one, and in some cases, relatives of the family.

DISCUSSION GUIDE TO FILM "The Medical Witness"

I. Preparation for court

A. Careful preparation is the key to effective testimony. As a general rule, whenever the physician suspects a case may involve child abuse, he/she should record the findings in detail, with complete descriptions of each injury and of all conversations with the parents and child.

B. The physician should carefully review his/her notes and records prior to testifying. Often, the doctor will be asked to describe his/her involvement with the case chronologically. The doctor should be prepared to testify as to when his/her examination of the child began and what specifically occurred thereafter.

C. Medical records should always be supoenaed in a child abuse hearing. The doctor should expect careful examination and cross-examination based on information contained in the records.

D. It is a good idea to talk with the attorney for the petitioner (county attorney, agency attorney, etc.) before the trial to review the case. You should review the case with the attorney and discuss the need for certain witnesses or documents. You should discuss the types of questions that will be asked of you, and "role-play" a few questions and answers with the attorney, for both direct and cross-examination.

E. In many cases, the attorney presenting the case will not arrange to review the doctor's testimony with the doctor until just before the hearing, if at all. For this reason, if the doctor is concerned about his/her testimony, or the attorney's ability to present it properly without prior preparation, the doctor should call the attorney and insist on a pre-trial meeting.

F. In every State, reporting laws suspend confidentiality between physicians and patients for purposes of reporting suspected child abuse and neglect. Therefore, the physician is legally required to report and, if subpoenaed, to testify.

G. In some abuse and neglect situations, the physician may have treated the family for some time, or may have attempted to work with the family around the dynamics of the abuse situation. In such instances, the physician may be very concerned about destroying the relationship that has been built up with the family by testifying in the abuse or neglect hearing. Although in an admittedly difficult position, this physician has a duty to protect the child and may have no alternative to testifying in the hearing. Physicians should realize that even if the child is removed from the home, they can continue to work with the family and to assist it in obtaining help, so that the child can be returned home as soon as possible. If they personally cannot continue to work with the family, they should assist others who can provide such help.

H. Many physicians are uncertain as to whether they are allowed to talk with the attorney for the parents or the attorney for the child prior to the hearing. There is no prohibition against such conversations; the doctor is free to act as he or she chooses. The doctor should be aware, however, that the attorney for the child or for the parents will cross-examine on any inconsistencies between what the doctor tells him/her informally and what the doctor testifies to in court.

I. The physician can usually arrange with the juvenile court to be placed on "stand-by" or "on-call" subpoena. This will allow the doctor to remain with his or her work until telephoned by the court, and avoid lengthy delays at the courthouse while waiting to testify.

II. Direct Examination

A. The medical witness presents evidence establishing the nature, extent and seriousness of the injuries to the child, as well as his/her opinion as to the cause of the injuries.

B. The doctor will *not* be expected to prove *who* caused the injuries to the child.

C. The doctor should testify objectively about his/her knowledge of the case and avoid becoming emotionally involved in the case while testifying.

D. The witness is allowed to use the medical records, or any other notes, to refresh his/her memory while testifying. Because the opposing attorney has the right during cross-examination to see such reports and notes and ask questions on information in them, the witness should be prepared to deal with unsupported opinions, inaccurate information, or inconsistencies between his or her testimony and the records or notes.

E. To testify accurately and authoritatively about the case, the witness should know these basic principles of testifying:

  a. Answer only the questions asked—do not volunteer information.
  b. If you do not understand the question, have it repeated. Never guess at what a question means.
  c. If you do not know the answer to a question, say so. Never guess at answer. If you are not certain of an answer, say you are not certain.
  d. Never get angry or defensive with the defense attorney. Be calm, cool, objective, honest and concerned about the family.
  e. If you are asked to give a yes or no answer and feel that such an answer would be misleading without an explanation, ask the judge to allow you to explain the answer properly, or indicate to your attorney that you want to explain that answer.
  f. Show respect for the court. Dress conservatively.
  g. Be exact in your testimony. For example, say "1 p.m." instead of "around noon," or "3 fractures" instead of "numerous fractures."
  h. Take time in answering questions. Think before you answer. Do not be hurried by the opposing attorney.
  i. Use laymen's terms when testifying. Be careful to explain all medical terms so that the judge and attorneys are able to understand your testimony.

Review, for example, the following terms and consider how you would explain them while testifying:

1. Subdural hematoma
2. Subconjunctival
3. Ecchymosis
4. Purpura
5. Laceration
6. Hemorrhage
7. Abrasion
8. Simple fracture
9. Compound fracture
10. Spiral fracture
11. Impetigo
12. Quadrant
13. Erythema
14. Trauma
15. Percentile
16. Growth curve
17. Poorly nourished
18. Well nourished
19. "Failure to thrive"
20. 1st degree burn/2nd degree burn/3rd degree burn
21. Anterior
22. Posterior
23. Superior
24. Inferior
25. Multiplanar

F. Some basic rules of evidence:

  a. Medical records are generally admissible as evidence. A physician is allowed to take these records on the witness stand to refresh his/her memory about the case.
  b. In general, the witness can testify only about those facts he or she knows personally, not about what others have said to him or her in order to prove the abuse or neglect. Hearsay evidence is inadmissible, but there are numerous exceptions to the rule, so check with your county attorney as to whether you will be able to testify about certain statements made to you. One important exception to the hearsay rule is that statements made to you by those involved directly in the case—i.e. the parents and children—are admissible.
  c. The expert witness is allowed to give opinions in areas related to his or her expertise. Most witnesses are allowed to testify only as to factual matters—what they have seen, heard, felt, etc. They are not allowed to give their opinions about what these facts mean. Physicians, however, as expert witnesses have

sufficient expertise and experience in medical areas so that they are allowed to express their opinions in order to help the judge or jury decide the case. For example, a physician usually qualifies as an expert who can give an opinion as to whether the child's injuries were accidental or not. Often, a social worker may qualify as an expert witness as to the behavior patterns of the parents or child. In order to qualify as an expert, the witness will be asked to state facts about his/her education and experience. The opposing attorney or judge may ask further questions about the witness's expertise, and then the judge will decide whether the witness qualifies as an expert. In each case, the judge has final discretion to decide whether a witness so qualifies.

d. Photographs can also be introduced as evidence. This may be done by the photographer's testimony (what kind of camera, lens, film, time of day, etc.) or by another witness's testimony, if the photo is illustrative of that witness's description of the scene depicted in the photo. For example, if a physician testified about the bruises and cuts on a child in the hospital and he/she was shown a picture of the child taken by the police at approximately the same time the doctor saw the child, the doctor is allowed to testify that the photo was a "true and accurate representation" of what he/she saw and the photo can then be admitted into evidence.

III. Cross-examination

A. Cross-examination is usually the most difficult part of testifying for the physician in a child abuse or neglect case. The key to effective performance during cross-examination is adequate preparation. The attorney for the petitioning agency should be able to assist the physician in preparing for cross-examination by pointing out the likely questions which will be asked and by role-playing the cross-examination.

B. It is important to remain calm on cross-examination. Do not become defensive, angry or condescending during cross-examination. It will diminish your credibility with the judge and will detract from your ability to respond competently to the questions asked.

C. Doctors are often cross-examined on the degree of certainty with which they are able to diagnose child abuse or neglect. Sometimes a physician is not in a position to be 100 percent certain of the diagnosis, but can articulate reasons to the court why, in his/her best medical judgment, he/she believes the injuries to have resulted from abuse or neglect.

D. Often the defense attorney questions the doctor about each specific injury separately, trying to suggest that each injury, by itself, might have been accidental. If the defense attorney is successful, he or she concludes by arguing that if each injury could have been accidental, then all the injuries could have been accidental and therefore, there is no good evidence that any abuse has occurred. A physician should make it clear to the court and to the defense attorney that it is the existence of numerous injuries, often in different stages of healing, which indicates that the child has been abused.

E. Another strategy often used by the defense attorney is to attack the physician's expertise by closely questioning him or her on his or her past involvement and experience with child abuse and neglect cases, trying to establish that the physician is not specifically experienced in the child abuse and neglect area. The defense attorney's strategy is principally designed to upset the witness. The physician should bear in mind that in the vast majority of cases, his/her overall professional background and experience will be sufficient to qualify him/her as an expert witness in the eyes of the court.

F. The defense attorney may attack the physician for failure to perform all medical tests needed to eliminate conclusively the possibility of natural causes for some of the child's injuries. If, in fact, the physician has not performed every possible test, he or she should be prepared to explain the reasons he or she felt the omitted tests were unnecessary in the case.

GLOSSARY OF SELECTED LEGAL TERMS IN CHILD ABUSE AND NEGLECT CASES

Abandonment The intentional failure of a parent to provide care for or maintain contacts with his/her child over a sustained period of time, as determined by State law. See TERMINATION OF PARENTAL RIGHTS.

Adjudicatory Hearing The juvenile or family court hearing in which it is decided whether or not the allegations of the petition (the complaint setting forth the specific acts of abuse and neglect against the parent) are true. The adjudicatory hearing is also known in some courts as the "jurisdictional hearing." The judge's decision about whether or not to place an abused or neglected child out of the home, or to make alternative treatment orders, is made in a separate hearing known as a dispositional hearing. A dispositional hearing is usually held at a later date.

Admissible Evidence which, under the technical rules applying in various kinds of law cases, may properly be presented to the judge or jury.

Adoption A legal proceeding in which an adult takes, as his or her lawful child, a minor who is not the adoptive parent's natural offspring. The adopted minor loses all legal connection to the previous parent(s), and the adoptive parent undertakes permanently the responsibility of providing for the child. Compare GUARDIANSHIP.

Affidavit A written statement, signed in the presence of a notary public who "swears in" the signer. The contents of the affidavit are stated under penalty of perjury. Affidavits are frequently used in the initiation of juvenile court cases, and at times are presented to the court as part of the evidence at a hearing.

Allegation A charge or a claim of fact in a petition or complaint, which must be proven if the petition or complaint is to be found true. In a child abuse or neglect case, the petition will contain allegations of the specific acts of abuse or neglect which the petitioner intends to prove at a trial.

Appeal Resort to a higher court, in the attempt to have the decision of a trial court changed. Usually appeals are made and decided upon questions of law only; issues of fact (e.g., did the minor suffer an accident, or was he intentionally injured?) are left to the trial judge, and seldom can be redecided in an appeal. Appeals in child abuse and neglect cases are rare.

Battered Child Syndrome The combination of physical and other signs which indicate to medical professionals that a child has received injuries by other than accidental means. Variations of the term are also used in the field, including "Parent-Infant Trauma Syndrome" (PITS), or "Maltreatment Syndrome." In some States, the battered child syndrome has been judicially recognized as an accepted medical diagnosis, admissible as evidence.

Best Interest of Child In many States, this is the standard for the judge to use in deciding an abuse or neglect case. Although vague and difficult to apply, it seeks to contrast decisions based on the interests of the child.

Burden of Proof The duty which falls on a party, usually upon the petitioner, of proving the allegations against a child or parent in a court trial. It is the petitioner's responsibility to prove the case; neither the child nor the parents have the duty to explain unproven allegations. See also STANDARD OF PROOF; and RES IPSA LOQUITUR.

Central Register Records of child abuse and neglect reports compiled under State law or voluntary agreement among public agencies. New reports of suspected abuse are checked to determine whether prior reports have been received concerning the same child or parents. The purposes of central registers are:

(1) To alert authorities of prior incidents of abuse or neglect among families who resort to different doctors or hospitals each time a child is injured.
(2) To assist agencies in planning for abusive families.
(3) To provide data for statistical analysis of child abuse.

Although access to register records is usually restricted, critics warn of increasing loss of confidentiality. Many registers do not provide means for verification of reports or expunction.

Circumstantial Evidence See EVIDENCE

Civil Proceeding Also called a "civil action," includes all lawsuits other than criminal prosecutions. Juvenile and family court cases are civil proceedings. See STANDARD OF PROOF.

Commissioner See HEARING OFFICER

Complaint
(1) An oral statement, made usually to police, charging criminal, abusive or neglectful conduct.
(2) A District Attorney's document which starts a criminal prosecution (also known in many states as an "information."
(3) A petitioner's document which starts a civil proceeding (in juvenile or family court, the complaint is usually called a "petition").

Conciliation Court See COURTS

Confidentiality Told in confidence, intended to be kept secret. Many communications from parent to doctor or social worker are "confidential," made so by statute, but may later be used in abuse or neglect hearings. State reporting laws specifically suspend rights of confidentiality by requiring physicians and social workers to report suspected cases of child abuse or neglect. See also PRIVILEGED COMMUNICATIONS.

Courts There is a variety of courts involved with child abuse and neglect cases, partly because different States divide responsibility for certain proceedings among different courts, and also because tradition has established a variety of names for courts which perform similar functions. Child abuse reports can result in proceedings in all the following courts:
(1) *Criminal Court*, usually divided into circuit or district court (which handles felony cases) and police or justice court (which handles misdemeanors and the beginning stages of most felony cases).
(2) Domestic Relations Court, a civil court in which divorces and divorce custody hearings are held.
(3) *Family Court*, a civil court in some States which combines the functions of domestic relations, juvenile court, and probate court.
(4) *Court of Conciliation*, a branch of domestic relations courts in some States usually staffed by counselors and social workers rather than by lawyers or judges, designed to explore and promote the reconciliation of divorcing parents.
(5) *Juvenile Court*, which has jurisdiction (legal power) over minors only, usually handling cases of suspected delinquency, status offenses, (e.g., runaways, children in need of supervision), and cases of suspected abuse or neglect. In many States, terminations of parental rights occur in juvenile court proceedings, while in other States such cases must be brought before another branch of the civil courts.
(6) *Probate Court*, which handles cases of guardianship and adoption and estates of deceased persons.

Criminal Prosecution The filing of allegations which constitutes a charge of crime, followed by the arraignment and trial of the defendant (unless PLEA BARGAINING resolves the case sooner). Criminal prosecutions may result in imprisonment, fines and/or probation.

Prosecuting attorneys have the power to decide which cases are actually prosecuted. Criminal defendants who cannot afford private counsel are usually entitled to be represented by attorneys in the Public Defender's Office.

Criminal defendants are entitled to acquittal unless charges are proven against them *beyond a reasonable doubt*. Criminal defendants are entitled to jury trials; in many civil proceedings concerning children there is no right to a jury trial.

Custody Hearing A court hearing held to determine whether a minor should be kept away from his parents until a full trial of neglect, abuse or delinquency allegations can be conducted. Custody hearings must usually be held within 24 hours of the filing of the abuse or neglect petition in any case in which the child previously has been placed in protective custody. See PROTECTIVE CUSTODY.

Delinquency Denotes behavior in a minor which, if committed by an adult, would be criminal conduct. Also includes, in some States status offenses, that is juvenile misbehavior not amounting to criminal conduct (e.g., children in need of supervision, "runaways").

Dependency Denotes the lack in a minor's life of proper parental care or supervision; distinguishes some juvenile court cases from others in which the minor is charged with delinquent conduct. Often a synonym for "neglect" or "wardship."

Detention See PROTECTIVE CUSTODY

Detention Hearing See CUSTODY HEARING

Disposition The order of a juvenile or family court which determines a treatment plan for a child, already proven to be abused or neglected. The main issue is usually whether the child should continue in or return to the parental home (and under what kind of supervision), or whether the minor should be placed out-of-home (and in what kind of setting: a relative's home, foster home, or an institution).

Dispositional Hearing The juvenile or family court hearing during which evidence is presented and arguments are made concerning the decision as to what should be done with a child already found to be abused or neglected. The dispositional hearing is usually held separately from the adjudicatory hearing.

District Attorney A government prosecutor of "suspected" crimes. See CRIMINAL PROSECUTION.

Domestic Relations Court See COURTS.

Due Process The rights of persons involved in court proceedings to be treated with fundamental fairness. These rights include the right to adequate notice in advance of hearings, the right to notice of allegations of misconduct, the right to assistance of a lawyer, the rights to confront and cross-examine witnesses, and the right to refuse to give self-incriminating testimony (but see IMMUNITY).

Evidence Any sort of proof submitted to a court for the purpose of influencing the court's decision. Some special kinds of evidence are:

(1) *Circumstantial Evidence:* proof of circumstances which may imply another fact. For instance, proof that a parent kept a broken appliance cord may connect the parent to infliction of unique marks on a child's body. A neighbor's testimony that he saw the parent strike the child with an appliance cord would be DIRECT EVIDENCE tending to prove the infliction. See also *RES IPSA LOQUITUR.*

(2) *Hearsay Evidence:* Testimony about an out-of-court statement made by someone other than the person testifying, and introduced into evidence in order to prove the truth of the matter asserted by that other person. For example, "I heard him say that the child had been left alone for ten hours." Such a statement would not normally be permissible to prove the fact that the child had been left alone for ten hours. Instead, it would be necessary for the person who actually made the statement to testify personally in the case so, at least, the opposing attorney would be able to cross-examine and "test" the truth or accuracy of that statement. There are numerous exceptions to the Hearsay Rule, however. For example, admissions or confessions made by a parent in a child abuse and neglect case may be testified to by a witness who heard the statement.

(3) *Opinion Evidence:* Although witnesses are ordinarily not permitted to testify to their beliefs or opinions (being restricted, instead, to reporting what they actually saw or heard), when a witness can be qualified as an expert on a given subject, he or she can report his or her conclusions (e.g., "Based upon these marks, it is my opinion as a doctor that the child was struck with a flexible instrument very much like this appliance cord.") Lawyers are also allowed to ask

qualified experts "hypothetical questions", in which the witness is asked to assume the truth of certain facts, and express an opinion based on those "facts".

(4) *Physical evidence, or real evidence:* any tangible piece of proof, such as a document, x ray print, photograph of scars or bruises, appliance cord, or pistol.

Exhibit See EVIDENCE: Physical Evidence.

Expert Testimony See EVIDENCE: Opinion Evidence. Witnesses with various types of expertise may testify in a child abuse or neglect case. Experts are usually questioned in court *first* about their education or experience which qualifies them to give opinions about certain matters. Only after the hearing officer decides that the witness is sufficiently expert in the subject matter may the witness proceed to state his or her opinions. Physicians, psychologists, psychiatrists and social workers are the most common expert witnesses in abuse cases.

Family Court See COURTS

Felony A serious crime, for which the authorized punishment is imprisonment for longer than a year, and/or a fine greater than $1,000. Distinguished from misdemeanor or infraction, both of which have lesser penalties.

Fifth Amendment The Fifth Amendment to the United States Constitution, guaranteeing several rights to criminal defendants. When a witness "takes the Fifth," he refuses to answer a question on the basis that his answer might tend to incriminate him—and the Fifth Amendment prohibits government from compelling self-incriminating testimony from any person (but see IMMUNITY; see also DUE PROCESS).

Guardian An adult appointed by a Probate or other Court to serve as custodian of a minor when the minor's parent is shown to be inadequate until the parent proves renewed ability to provide proper care to the child. A guardian has almost all the rights and powers of a natural parent, but the relationship is subject to termination or change (compare ADOPTION).

Guardian Ad Litem In civil cases generally, an adult, often a member of the minor's family, who is appointed by a court to act in the minor's behalf *ad litem* (in a lawsuit), because minors lack the legal capacity to sue or defend against suit. Guardians *ad litem* are sometimes known as NEXT FRIENDS. In child protection cases, usually an attorney, probation officer, or child protection worker assigned to protect a child's interests in court. (Under the Federal Child Abuse Prevention and Treatment Act of 1974, States cannot qualify for Federal grants unless they enact statutes providing guardians *ad litem* for all children involved in judicial proceedings arising from child abuse or neglect).

Hearing Officer The individual who presides at a judicial proceeding. The role of judge is performed in some juvenile court hearings by referees, commissioners or masters, whose orders are made in the name of the supervising judge. The orders of a referee or commissioner may be rescinded by the supervising judge after he/she has conducted a rehearing in the case.

Immunity Legal protection from liability.

(1) Reporting statutes require certain persons to report suspected child abuse; the same statutes often confer immunity upon the persons required to report, giving them an absolute defense against libel, slander, invasion of privacy, false arrest and other lawsuits which disgruntled parents might file. Even when the report turns out to have been false, reporters have immunity from liability so long as they acted "in good faith" when they reported.

(2) In criminal prosecutions, immunity from *criminal* liability is sometimes conferred upon a witness in order to secure from him vital testimony against others. Thereafter, the witness cannot himself be prosecuted with the use of information he disclosed in his testimony. Sometimes the witness is granted total immunity, called "transactional immunity." He can be compelled to testify in this way, despite the Fifth Amendment's protection against self-incrimination. If an immunized witness refuses to testify, he can be imprisoned for contempt of court.

Jurisdiction The power of a court to hear particular types of cases. Three general areas are relevant in determining whether a court has jurisdiction in a particular case:

(1) The subject matter of the case (e.g., criminal prosecution, divorce, child protection).
(2) The territorial limitations of the court (e.g., where the parties and/or defendants reside, where the property whose title is in dispute is located, where the criminal acts occurred.
(3) The procedures used to notify the defendants that a case has been filed (e.g., was service of summons properly made).

Generally speaking, juvenile courts have subject matter jurisdiction over cases including minors. They have geographic jurisdiction over an entire county, and they have jurisdiction over minors or their parents only if they have been given proper legal notice of the proceedings.

Jury A group of adults, selected by lawyers or the judge from a panel, to judge the truth of allegations made in a legal proceeding. Trial by jury is available in all criminal cases, including cases of suspected child abuse. But very few states convene juries in juvenile court, probate court or divorce court cases; those cases are, instead, "court cases" in which the truth of allegations is determined by the judge who presides.

Juvenile Courts See COURTS.

Juvenile Judge See HEARING OFFICER. In many juvenile courts, there is one presiding judge, and several other hearing officers of lesser rank, usually called referees, commissioners or masters.

Malice The intentional doing of a wrongful act without justification, with the intent to inflict an "injury" or "harm." Sometimes malice is inferred from the doing of an act which the actor should reasonably have known would produce injury or harm.

Master See HEARING OFFICER.

Miranda Rule In a famous U.S. Supreme Court case, it was decided that confessions would be inadmissible in court trials if the suspect had not been forewarned by the police of certain constitutional rights. The so-called "Miranda rights" include:

(1) The right to remain silent, to say nothing to the police.
(2) The right to know that anything the suspect says can be used against him/her in a court of law.
(3) The right to consult with an attorney and to have an attorney present during questioning.
(4) If he cannot afford a lawyer, the right to have one appointed prior to any questioning, if so desired.

This rule clearly applies to police investigations of criminal child abuse or neglect. As a matter of good police practice, the Miranda warnings are also given by law enforcement officers in cases which may involve only the juvenile court. The U.S. Supreme Court has not yet ruled on the issue of whether child protective service workers must also give Miranda warnings when investigating suspected child abuse or neglect. As a general practice, such warnings are not now given by child protective service workers in most States, because the purpose of the child protective investigation is not primarily to obtain evidence for criminal prosecution, but the possibility exists that such warnings may someday be required by the courts.

Misdemeanor A category of crime, for which the authorized punishment is *no more* than one year imprisonment (usually in a county jail rather than state prison) and/or a fine of $1,000. Distinguished from a felony, which has more serious penalties, and from an infraction, which has less serious penalties.

Negligence Any act or failure to act which a "reasonably prudent person" would not have done or failed to do. Lawsuits claiming damages for negligence are civil proceedings. Negligence suits arising from failure to report suspected child abuse are being filed with increasing frequency. Where reporting statutes exist, any failure to obey the statutes in itself is considered negligence, supplying a major element in a subsequent suit.

Next Friend See GUARDIAN AD LITEM

Parens Patriae "The power of the State." The State's power to act "for" or "on behalf of" persons under legal disability, such as minors, incompetents or insane persons.

Perjury Any intentionally false testimony.

Petition The document filed in juvenile or family court at the beginning of a neglect, abuse or delinquency case. A copy of the petition must be delivered to specified members of the family involved. The petition sets forth the allegations which, if true, form the basis for court intervention. (See ALLEGATIONS.)

Petitioner In juvenile or family court practice, the agency or individual who files the petition. Depending upon State law or county practice, most child abuse and neglect petitions are filed by child protective services, the county prosecutor and/or the juvenile court probation department.

P.I.T.S. (Parent Infant Trauma Syndrome) See BATTERED CHILD SYNDROME.

Placement The removal of a child from his or her natural home, and placing him or her in a different custodial setting. Placement may be in a shelter home, foster home, group home, relative's home, or an institution. Juvenile or family courts sometimes place minors through their own staffs, but usually commit delinquents or dependent children to other agencies for placement services.

Plea Bargaining Settlement of a criminal prosecution, usually by the reduction of the charge and/or the penalty, in return for a plea of guilty.

Police Hold See PROTECTIVE CUSTODY.

Prima Facie "On its face." A prima facie case is one which has been proven sufficiently to sustain the charges, unless the defendant or parent can produce evidence in rebuttal.

Privileged Communications Some confidential communications are protected by statutes, so that they need not nor cannot be disclosed in court over the objection of the holder of the privilege. Lawyers are almost always able to refuse to disclose what a client told them in confidence. Doctors and psychotherapists have generally lesser privileges, and their testimony can be compelled in cases involving child abuse or neglect. Priests are similarly covered by other statutes. Some social workers are covered by such statutes. But the law and practice vary widely from State to State (see CONFIDENTIALITY).

Probate Court See COURTS.

Probation In criminal or delinquency cases, a disposition which allows the convicted criminal defendant or the juvenile found to be delinquent to remain at liberty, under a suspended sentence of imprisonment, generally under the supervision of a probation officer, and usually under certain conditions. In child protective cases, a disposition which provides legal authority for the agency to supervise the conditions of the home. Violation of a condition is ground for revocation of the probation and it is by this power of the court to condition the release of a child, and to revoke the release later, that juvenile courts obtain practical power over adults. The court may require parents to make certain promises as a condition of returning the child to the parental home, and can enforce the promises with the threat of revocation.

Protective Custody In child abuse and neglect cases, refers to the emergency removal of a child from the custody of the parent(s) or caretaker(s). Protective custody is allowed only when a child is in imminent danger if he/she remains in the custody of parent(s) or caretaker(s). Abused or neglected children placed in protective custody are usually taken to hospitals, shelter homes, foster homes or juvenile halls pending the juvenile court hearings on the abuse or neglect petition.

Public Defender See CRIMINAL PROSECUTION.

Referee See HEARING OFFICER.

Rehearing After a juvenile court referee or master has heard a case and made an order, some States permit the dissatisfied party to request another hearing before the supervising judge of juvenile court. This second hearing is called a rehearing. If the original hearing was not recorded by a court reporter, the rehearing may have to be granted. If a transcript exists, the judge may read it and either grant or deny the rehearing.

Reporting Statutes Laws which require specified categories of persons (usually professionals involved with children) to notify public authorities of instances of suspected child abuse, and sometimes neglect. All 50 States now have reporting statutes, but they differ widely with respect to:

(1) Types of instances which must be reported,
(2) Persons who must report,
(3) Time limits for reporting,
(4) Manner of reporting (written, oral or both),
(5) Agencies to which reports must be made, and
(6) The degree of immunity conferred upon reporters.

Res Ipsa Loquitur Literally, "The thing speaks for itself." A legal doctrine of evidence which changes the ordinary rules affecting the burden of proof (see BURDEN OF PROOF). It is used mainly in certain types of cases involving personal injury or property damage and has been applied by some courts to child abuse and neglect cases. When an injury occurs under circumstances which ordinarily indicate that someone must have been negligent or otherwise responsible for the injury, it becomes the legal duty of that person to prove that he or she was not, in fact, negligent. When a small child or infant suffers certain types of injuries which do not ordinarily occur if the parent or caretaker who has responsibility and control of the child is protective and nonabusive, application of the doctrine requires the parent or caretaker to adequately explain how the injuries occurred other than by abuse or neglect. The doctrine is used in some abuse and neglect cases where the child victim is too young to testify and there are no eye-witnesses to the injurious conduct other than the parent or caretaker.

Review Hearing Many States require juvenile and family courts to make periodic, sometimes annual, reviews of dependency cases to determine whether continued court supervision is necessary, and to provide some judicial supervision of probation or casework services.

Sentencing The stage of the criminal prosecution in which a convicted defendant is ordered imprisoned, fined, or granted probation.

Social Study The document prepared by a probation officer or social worker for the juvenile or family court hearing officer's consideration at the time of disposition of a case. This report addresses the minor's history and environment. These reports often contain material which would clearly be inadmissible in most judicial proceedings, either because of hearsay or lack of verification or reliability.

Standard of Proof (quantum of proof) In different judicial proceedings there varying requirements of proof. For example, in criminal prosecutions it is necessary for the State to prove the guilt of the accused "beyond a reasonable doubt." In child abuse and neglect cases in the juvenile or family courts, as in other civil proceedings, the petitioner (plaintiff) must prove the existence of abuse or neglect "by a preponderance of the evidence," a significantly lesser standard. The "preponderance of evidence" standard is often interpreted to mean that the judge or jury must believe that "it is more likely than not" that abuse or neglect exists. In some States, the standard of proof applicable in abuse and neglect proceedings is "clear and convincing evidence," a somewhat higher standard than "preponderance of evidence."

Stipulation An agreement (sometimes oral, sometimes written) between the attorneys in a case which allows a certain fact to be established in evidence without the necessity of further proof. For example, the lawyers in a child abuse case may "stipulate" that the x rays showed a fractured arm so that the radiologist would not have to be subpoenaed and testify.

Subpoena A document issued by a court clerk, usually handed by a process server, a child protective service worker, or a law enforcement officer to the person subpoenaed, requiring that person to appear at a certain court at a certain day and time, to give testimony in a specified case. Failure to obey a subpoena is punishable as a contempt of court.

Subpoena Duces Tecum A subpoena requiring the person subpoenaed to bring to court with him or her specified records if they are within that person's control.

Summons A document issued by a court clerk, usually handed in person to the person summoned, notifying that person of the filing of a lawsuit against him or her, and notifying that person of the deadline for answering the suit. Compare SUBPOENA.

Termination of Parental Rights A legal proceeding to free a child from his or her parents' claims, so that the child can be adopted by others without the parents' written consent. The legal bases for termination differ from State to State, but most statutes include as a ground the failure of the parent to support or communicate with the child for a specified period of time; thus such suits are also often called "abandonment" cases.

Voir Dire "To speak the truth." The procedure during which lawyers question prospective jurors, to determine their biases, if any. Also the procedure in which lawyers examine expert witnesses regarding their qualifications, *before* the experts are permitted to give opinion testimony.

Warrant A document issued by a judge, authorizing the arrest or detention of a person, or the search of a place and seizure of specified items in that place.

Willful Done with understanding of the act, and the intention that the act and its natural consequences should occur.

Witness
(1) A person who has seen or heard something.
(2) A person called upon to testify in a court proceeding.

Unit 8: COMMUNITY PLANNING AND COORDINATION TO PREVENT AND TREAT CHILD ABUSE AND NEGLECT

UNIT 8.

Time: 2 hr. 55 min.
(3 hr. 20 min. optional)

COMMUNITY PLANNING AND COORDINATION TO PREVENT AND TREAT CHILD ABUSE AND NEGLECT.

DESCRIPTION OF UNIT:

This unit focuses on interagency and multidisciplinary issues in dealing with the problems of child abuse and neglect at the community level. It contains: (1) a documentary-style film, which provides information about how three communities have put together and maintained multiagency child protection efforts; (2) a simulation exercise/role-playing allowing the group to practice and observe interagency collaboration; and (3) a group discussion, to allow for analysis and planning of the group's own community needs for better community and interagency coordination.

GOALS:

1. To provide participants with models of successful community planning and coordination of child protection efforts, in order that they may consider their own agency and individual roles in such local efforts.
2. To provide participants with an experience in multidisciplinary/multiagency planning and coordination, through the vehicle of a simulation exercise, in order that they may define for themselves some of the opportunities as well as the difficulties of such endeavors.
3. To allow participants an opportunity to consider the needs, barriers and opportunities to develop or strengthen interagency and multidisciplinary approaches to the prevention and treatment of child abuse and neglect in their own community.

OBJECTIVES:

At the conclusion of this unit, participants will be able to:

1. Describe how multidisciplinary councils were formed in the three communities in the film.
2. List at least six different professions that might be represented on a multidisciplinary/multiagency council or team.
3. Describe three problems commonly encountered in the formative period of a multiagency/multidisiplinary council or team.
4. List three ways in which a multiagency/multidisciplinary council or team might be used (or strengthened) in their own community.

RATIONALE:

The entire **WE CAN HELP** curriculum is based on the premise that child abuse and neglect pose problems for communities which can be addressed effectively only when various professionals and agencies pool their expertise and their resources. Roles and perspectives on the problem necessarily differ, depending on the type of service that a professional or an agency can deliver; but through clarifying those roles and defining those perspectives clearly for each other, those with responsibility for the well-being of children and families are able to bring their services to bear in preventing and treating child maltreatment. This particular unit allows for the further refinement of participants' understanding and respect for what each can contribute to child protection and family-supportive services. Such clarity and understanding will usually not come without some disagreement and defensiveness. The leader's role in this unit should be not to suppress such tensions, but to help participants work through them by continually focusing on the primary goal: to prevent and treat child abuse and neglect using all of the community's available resources.

ADDITIONAL STAFF NEEDED:

None

SPACE REQUIREMENTS:

One room large enough to accommodate total group.

EQUIPMENT:

16 mm. sound projector
Screen

Extension cord and adapter plug, if necessary
Easel board and pad of easel paper or chalkboard
Felt-tip markers or chalk and eraser

AUDIOVISUALS:

Film: *"Working Together"*

BEFORE YOU BEGIN:

Choose from participants six role-players and six role observers for Activity 2. Duplicate a copy of each *role profile* for role players and role observers and a copy of the *problem statement* for all participants. Duplicate sufficient copies of the discussion questions for passing out to all participants in Activity 3. Duplicate sufficient copies of the post-test (optional) for all participants (Activity 4). Be sure to preview the film, "Working Together," and formulate your own answers to the questions for discussion.

ACTIVITY	TIME	MATERIALS
1. Film and Discussion	55 minutes	Film: "Working Together"
BREAK	10 minutes	
2. Group Exercise: "A multidisciplinary Simulation of Community Programming for Child Abuse and Neglect"	60 minutes	Simulation Materials • Problem statement • 6 role profiles
3. Leader Presentation and Group Discussion: "Local Planning"	45 minutes	Questionnaire for "Local Programming" Easel pad Markers
4. Post-test (Optional)	30 minutes	Post-tests

PARTICIPANTS' MATERIALS:

(See materials above to be duplicated from "Leader's Manual")
Simulation exercise-role profiles (1 each)
Simulation observer-role profiles (1 each)
Simulation exercise problem statement (enough for all participants)
Discussion questions for community planning (sufficient for all participants)
Post-tests (sufficient for all participants)

252

ACTIVITIES

ACTIVITY 1. FILM AND DISCUSSION

55 minutes
Introduce unit with goals (2 minutes)

The leader introduces the unit by listing the goals of the unit:

1. To provide participants with models of successful community planning and coordination of child protection efforts, in order that they may consider their own agency and individual roles in such local efforts.
2. To provide participants with an experience in multidisciplinary/multiagency planning and coordination, through the vehicle of a simulation exercise, in order that they may define for themselves some of the opportunities as well as the difficulties of such endeavors.
3. To allow participants an opportunity to consider the needs for, barriers to, and opportunities for developing or strengthening interagency and multidisciplinary approaches to the prevention and treatment of child abuse and neglect in their own community.

Introduce film (2 minutes)

The first activity uses a film, "Working Together," which is a documentary-style presentation of three community child abuse and neglect councils. Each involves a number of professions and a number of agencies.

Questions to ask of film

Participants should look for the answers to these questions (which will be discussed after the film is over):

1. How did the multidisciplinary/multiagency effort get started in each community?
2. How is the council's work funded, and how expensive is it in each community?
3. What kinds of agencies and what kinds of professional disciplines are represented on the council in each community?
4. What functions does the multidisciplinary/multiagency council perform in each community?

Show film (30 minutes)

FILM

Discuss film (20 minutes)
Use four questions on content

Discussion:

Using the four questions above, the leader has participants reiterate the main points from the film. It may be necessary to agree that no two communities are completely alike; yet there are basic planning and coordination needs and problems that all communities seem to share.

Discuss common community problems

For instance, problems of agency "turf" seem to crop up in almost every community. Problems of "breakdowns" in lines of communication between agencies or professionals are very common and have caused some tragic results in cases involving child protection. Issues of how best to handle *self-referrals* of "high risk" or already abusive or neglectful parents to private service agencies require a level of trust and direct communication between the mandated child protection agency and the private service provider. Response to these and other issues may be elicited in the course of the discussion. It may be helpful in Activity 3 if they are recorded on a separate piece of easel pad paper for later reference.

BREAK **10 minutes**

ACTIVITY 2. SIMULATION EXERCISE AND DISCUSSION

60 minutes

Introduce simulation (3 minutes)

The next activity is a simulation or a role-play of a Task Force on Child Abuse and Neglect. This simulation was developed by Adrienne Haeuser, MSW, of the University of Wisconsin School of Social Welfare in Milwaukee, and is entitled "All for the Cause and the Cause for Each." The leader should have chosen in advance six role-players and six role-observers and have given them each a copy of the *problem statement* and the appropriate role profile or observer guide.

The leader introduces the *roles* and asks the role-players to assume their positions in a semi-circle (preferably behind a table) in front of the group. Role-observers should sit outside the semi-circle but opposite their role-players in order to observe fully how they present their points of view.

Introduce simulation problem and roles (5 minutes)

The leader then reads the problem statement, the roles and the instructions:

(PROBLEM STATEMENT)

You live or work in Middlefield, USA, and have been appointed to the recently created Middlefield Task Force on Child Abuse and Neglect, whose task is to determine the most effective way for Middlefield to impact on this problem. The Task Force evolved because a significant increase in child abuse reports has prompted the state to make some additional funds available to localities which provide comprehensive multidisciplinary, multiagency community team programs for prevention, identification and treatment. The Middlefield Planning Federation has also assigned top priority to child abuse and neglect for new program funding. The *Middlefield News* has published several child abuse horror stories in recent months, one involving a rather prominent young businessman, and many Middlefield citizens, as well as professionals, believe the time has come for Middlefield to take action.

Unfortunately, it took so long to determine which organizations should be represented on the Task Force and for the organizations to determine who the representative would be that the deadline for the Task Force report to both the State and the Planning Federation is imminent. Therefore, a recommendation as to how to spend the new money available must be finalized at this meeting or the new money will not be available from either the State or the Planning Federation.

The roles for the Task Force Meeting are:

- Dr. Pace—a pediatrician
- Chris Stein—child protective services supervisor
- Judge Jefferson—juvenile court judge
- Wanda Clark—Junior Women's Club President
- John Hunter—Mental Health Association President
- Pat Fox—Planning Federation Director and Task Force Chairperson

Let the meeting begin:

Begin Task Force Meeting

TASK FORCE MEETING SIMULATION

(30—35 minutes)

Discussion:

Role-players express feelings

After 30–35 minutes, the leader should end the simulation and lead a discussion about it. First, the leader asks the *role-players* to share their feelings about what was and was not concluded. (Players need this opportunity to ventilate and to return to reality).

Role-observer commentary and group discussion of biases and stereotypes
Pediatrician

Next, the pediatrician *role-observer* is asked to read and respond to the questions posed in the role observer guide, followed by an open discussion of the bias and stereotype portrayed by the physician. The leader should attempt to gain a consensus about two or three characteristics of the medical profession and practice which represent barriers to multidisciplinary community problem-solving, particularly with respect to child abuse and neglect. These may be listed on an easel pad or the chalkboard. The group should be encouraged to discuss the origin of these characteristics.

Judge, Child Protective Services supervisor

The leader should follow the same process with the other two disciplinary roles, the judge and the child protective services supervisor, calling on the respective role-observers.

Junior Women's Club President; Mental Health Association President

The Junior Women's Club President role-observer and the Mental Health Association President role-observer, respectively, should then read and respond to the questions posed in their role observer guides. Then the discussion should be opened to the group focusing on the perspectives revealed by these nonprofessionals. The group should attempt to reach several conclusions about how professionals perceive and respond to nonprofessionals and vice versa, with respect to child abuse and neglect.

Planning Federation Director

Finally, the leader asks the Planning Federation Director role-observer to read and respond to the questions posed in the role-observer guide. The group discussion should focus on why the Planning Federation Director's role is difficult.

Leader's note

Leader's Note: Remember that you, as the facilitator of this exercise, should not allow yourself to become the target for criticism for the biases or stereotypes that are *written into* the roles. Do not accept this criticism, but rather place it where it belongs, on the author of this simulation exercise. However, you may note that the author's intent is not to provide conclusions about professions or persons but rather to stimulate examination. If the criticism seems to stem not from the role itself but from the way it was portrayed by a role player, you may want to suggest that the role profile be read aloud in order to shift the focus of the discussion.

Group discussion of the meeting

The final part of the discussion may center around these questions:

- What seemed to influence the group process most profoundly? Why?
- How alike or different are the values expressed by the doctor, social worker and judge?
- Do the nonprofessionals express values in common?
- Is there friction between particular professionals?
- Did one professional dominate the others? Why?
- Is there friction between the professionals and the nonprofessionals? Why?
- How do the settings in which the professionals practice influence their contributions?
- Can you rank the physician, judge and social worker in terms of greatest identification with their profession? What seemed to be the basis for this?

On the basis of today's meeting, where would the new money be allocated?

ACTIVITY 3. LEADER PRESENTATION AND GROUP DISCUSSION: "Local Planning"

45 minutes

Focus on local planning and coordination needs

This activity provides an opportunity to initiate a process of local planning for multidisciplinary/multiagency coordination. If a vehicle for such coordination already exists in your community, this time can be used to discuss ways of strengthening it and expanding its effectiveness.

Summarize coordination issues from earlier units

The leader should remind participants who have had the benefit of earlier units of the **WE CAN HELP** curriculum of some of the local issues that arose in discussions of identification, reporting, case management and court involvement.

The issue of how to encourage and handle self-referrals

An additional issue was briefly mentioned in an earlier unit, namely the need to develop approaches to child protection which will encourage families who know themselves to be abusive or neglectful, and who are motivated to change their behavior and improve their ability to be more nurturing to their children, to refer themselves for treatment and family-supportive services. Clearly, such motivation makes the chances for successful treatment much higher. It may be that agencies other than the child protection agency can best receive such self-referrals; but in that case, clear procedures need to be worked out so that legal requirements to report known or suspected cases of child maltreatment are not subverted while at the same time the optimal opportunities for treatment of self-referring families are afforded.

Prevention

Finally, an issue about which all human service agencies and all care-giving or educational professionals share concern is that of *prevention* of child maltreatment. Prevention is an interagency issue, involving social services, health care, education, law enforcement, mental health and all the other agencies that can have some influence on preparation for parenthood, family stress reduction, and the general quality of the community's welfare.

Questionnaire for Local Planning

To aid in the discussion of local issues and approaches, the leader hands out copies of the "Questionnaire for Local Planning" and allows about 5 minutes for participants to read it and mark their answers. (The first set of 8 questions is for communities with no local task force or council; the second set of 5 questions is for communities that do have a council or task force already.)

Discuss questions

Use the questionnaire as the basis for a group discussion on your community.

Conclude with 3 action steps.

On the basis of the group's discussion of the questions, try to lead the group to define 3 specific action steps *that can be accomplished* and that would improve the community's ability to plan and coordinate child protective services on a multidisciplinary/multiagency basis.

ACTIVITY 4. (OPTIONAL) POST-TEST

30 minutes

The leader introduces this activity and has the training staff hand out the post-test.

After participants have completed the test, the leader may expose an easel pad sheet with correct answers. Otherwise, participants may hand in tests for grading by the training staff. Provision should be made to inform participants of the comparison between their pretest and post-test scores.

ALL FOR THE CAUSE AND THE CAUSE FOR EACH

A Multidisciplinary Simulation

PROBLEM STATEMENT

You live or work in Middlefield, USA, and have been appointed to the recently created Middlefield Task Force on Child Abuse and Neglect (CAN), whose task is to determine the most effective way for Middlefield to impact on this problem. The Task Force evolved because a significant increase in child abuse reports has prompted the state to make some additional funds available to localities which provide comprehensive multidisciplinary, multiagency community team programs for prevention, identification and treatment. The Middlefield Planning Federation has also assigned top priority to child abuse and neglect for new program funding. The *Middlefield News* has published several child abuse horror stories in recent months, one involving a rather prominent young businessman, and many Middlefield citizens, as well as professionals, believe the time has come for Middlefield to take action.

Unfortunately, it took so long to determine which organizations should be represented on the Task Force and for the organizations to determine who the representative would be that the deadline for the Task Force report to both the state and the Planning Federation is imminent. Therefore, a recommendation as to how to spend the new money available must be finalized at this meeting or the new money will not be available from either the state of the Planning Federation.

ROLES

A. Pediatrician—Dr. Pace
B. Protective services supervisor—Chris Stein
C. Juvenile court judge—Judge Jefferson
D. Junior Women's Club President—Wanda Clark
E. Mental Health Association President—John Hunter
F. Planning Federation Director (Task Force Chairperson)—Pat Fox

INSTRUCTIONS FOR ROLE PLAYERS

A. Participants should not look at each other's roles.
B. Each person should read the part carefully and play the role conscientiously.
C. Put yourself in the role and add your own ideas *consistent* with the role.
D. Participants should not over-act.
E. Be natural, but emphasize behavior aimed at fulfilling your role.
(Each role-player should receive this page attached to a specific role profile.)

PEDIATRICIAN ROLE PROFILE
Dr. Pace

Personality:

You feel that nine years of medical education, internship and pediatric residency, which for you were a grueling mental and financial struggle, clearly *entitle* physicians, and especially you, to more authority than professionals from other disciplines. Your active participation in the Middlefield Chapter of the American Medical Association and the publications you receive from the AMA *reinforce* your feelings of professional *status* and *power.* You believe, and it is usually your experience, that your opinion carries weight. You behave as though you are the *only expert* on the Task Force. If the Task Force does not readily acknowledge your authority, you should modestly point out your education and the AMA as bases for your *"superiority."*

Since you are accustomed to giving orders to nurses and other hospital staff, you should interact with the social worker and Planning Federation Director as though you were *giving them orders.* However, you show some deference to the judge.

You sincerely believe that as a doctor you serve humanity. However, you also enjoy your high income and you are impatient for a *quick conclusion* of these meetings which are for the community's good because you want to get back to your *private practice.* You make a mental note that, unlike the other professionals present who are participating on agency time and money, you are losing money every minute you are away from your office or the hospital. Therefore, you *announce* as soon as the meeting begins that you will only be able to stay a short time and probably should be *heard from first.* As the meeting progresses, you get involved in the discussion and *do not* in fact leave, but instead *tell the Task Force* why you are getting *more impatient* with each passing minute.

Bias To Be Expressed:

You prefer working with your own colleagues and within your own medical setting. For this reason, and because you see child abuse and neglect as a *physical* blood and bones problem, you have *already* determined that Middlefield Hospital, with which you are affiliated, should be the base for *any* new programs and funds. You will support programs which can be managed from the hospital under *medical* direction and when the meeting opens, you lose no time in authoritatively reporting this conclusion.

Your Recommendation:

You recommend funding a position for a case manager at Middlefield Hospital to work with a committee of hospital staff, including pediatricians, radiologists, nurses, the hospital social worker and a psychiatrist to review all in-patient and out-patient hospital admissions which present any possibility of child abuse or neglect. You have tried to organize such a committee at the hospital, but the hospital will not fund a position to keep the committee's records and provide coordination of the various committee members' input. . You would be happy to chair the committee, particularly if some funds were available *for your time* also.

CHILD PROTECTIVE SERVICES SUPERVISOR ROLE PROFILE

Chris Stein

Personality:

You feel *overworked* and *underpaid*, but you are a dedicated social worker and want to do a good job carrying out the state's mandate for investigation of child abuse and neglect reports by your department. You also feel that it is impossible for anyone who hasn't had actual experience in child protection work to appreciate how *stressful* it is. Therefore, when people criticize your department—as has been the case with the recent uproar in Middlefield—you are both *defensive* and *hostile.*

You are particularly *defensive* now because, despite your best supportive efforts, you have had a *complete staff turnover* in the past eight months and you know that your workers need more training and experience. You are *hostile* not only because the community doesn't appreciate your problems but also because your own agency doesn't give you funds or authority to make significant changes. *You will not be able to commit your agency* to any recommendation from today's Task Force meeting, but rather you will take it back to your agency administrator for discussion and, hopefully, approval.

Periodically, but particularly when the discussion isn't going along with your biases and recommendation, you *point out* that you would really need to discuss the matter with your agency administrator to determine whether it is in accordance with *agency policy.*

Bias To Be Expressed:

Since your program is mandated by law to investigate CAN reports, you and your agency administrator *have already concluded* that Child Protective Services should be responsible for all child abuse and neglect programming in the community. You are *very verbal* on this point. Furthermore, you point out to the Task Force that social work is, after all, a *humanitarian profession* and therefore the most logical framework for treating social problems.

Since you are regularly accountable to your agency director and also issue an annual report, you see *no need for any citizen involvement* in your program. You will resist any proposals linking your agency to citizen groups, since this would only complicate the heavy burden you already bear in supervising and upgrading your staff.

Your Recommendation:

You know that your staff lacks time and, in some cases, training to undertake long-term intensive casework or to locate resources and facilitate referrals to supportive services, so you hope the projected new money will be earmarked for *more* and *better qualified staff* in *your* program. This is your primary recommendation. Secondarily, you also have dreams of money for *in-service training* and *staff development.*

JUVENILE COURT JUDGE ROLE PROFILE

Judge Jefferson

Personality:

You are a *dignified, methodical,* rather *formal* and *pompous* person accustomed to being addressed as *"Your Honor."* (If you have a beard, stroke it!) Yet you do have great sensitivity to human need, and as a judge you feel *frustrated* because you hear so many cases where charges of abuse or neglect aren't substantiated by *legal evidence.* You wonder what happens to these families, but you realize you weren't trained or elected to run a social service agency.

Since you are accustomed to seeking information before making a decision, you take a *very active role in drawing out viewpoints* from all the other members of the Task Force. Besides, with an election coming up soon, you need *visibility!*

Bias To Be Expressed:

In court you *expect* protective services workers to provide expert testimony which isn't always forthcoming. You wonder why they can't make *definitive judgments* the way lawyers do. You need to know whether a child will be subjected to re-injury if left in the family or not. You're looking for a "yes" or "no" from the social worker, and you get five inconclusive paragraphs. You use the Task Force as a place to *make a small speech about this frustration, pointing out* that you know from your participation in the *Middlefield Bar Association* that other judges and attorneys also are frequently disenchanted with *indecisive social workers.*

Your Recommendation:

Besides giving yourself visibility and ventilating your frustration, your objective on the Task Force is to suggest the *possibility* of upgrading the capability of the child protective services staff. You recommend more staff and more highly trained staff, although you *admit to wondering* whether any amount of training will *enable a social worker* to make definitive judgments.

If the protective services staff were more willing to get involved with *other community resources* such as the Mental Health Association or the voluntary family agencies, you would recommend using the new money for protective services *in-service training in case management and coordination.*

On the other hand, you have heard such good things about *Parents Anonymous,* a self-help program in other communities, and you are so ambivalent about social workers, that *you also recommend* the possibility of turning the new money over to a *volunteer group* to initiate Parents Anonymous in Middlefield. You announce that in that case you might even stipulate attendance at Parents Anonymous as part of your sentencing procedure.

JUNIOR WOMEN'S CLUB PRESIDENT ROLE PROFILE

Wanda Clark (female role)

Personality:

You are a *warm, caring, giving* person both as the *mother* of five well-adjusted children and as a *community leader* who manages to give time as either a board member or volunteer to most of the human service programs in Middlefield. In short, you have beauty, brains, and energy besides warmth and sensitivity to human need.

You are very *persuasive* and an acknowledged community leader, even though you moved to Middlefield only four years ago.

Bias To Be Expressed:

You believe that *every family* experiences stress, even yours, and yet you know that families don't seek assistance early because it's embarrassing, if not *stigmatizing*, but rather wait until the crisis is often beyond repair. Because of the *stigma associated with the child protective service program*, you don't feel it can be very effective in early intervention.

You are also *unsympathetic* with protective services because they do not utilize *volunteers* nor have any kind of *community advisory board*.

You believe that *prevention* is just as important as treatment.

Your Recommendation:

You *point out* to the Task Force that in the city you came from you were involved in developing a Parent Aide program utilizing trained volunteers to "befriend" families-at-risk. The Parent Aides give "tender—loving—care" and nurturing to the abusive parents. The Parent Aide program seemed to be effective and you recommend that the Middlefield Junior Women's Club undertake a similar program. The Club could provide volunteers, and you have already determined that faculty at the local university could be made available to develop/supervise *volunteer training*.

You recommend that the *family agencies* and the *mental health agencies* in the community be actively involved in any new programs, particularly the development of the Parent Aide program.

You have also heard that some other communities have *help-lines* using trained volunteers to make help unthreatening and immediately available, and you think any new monies might well be utilized for this purpose also.

You understand that the pediatrician has been trying to convince the hospital to do something about child abuse and neglect, but you are *adamant that citizens*, as well as doctors and other professionals, should spearhead any new program development.

MENTAL HEALTH ASSOCIATION PRESIDENT ROLE PROFILE

John Hunter (male role)

Personality:

As the owner of a large, very successful public relations agency, you are an aggressive, blustery ad-man type. Because of you ability to *influence* people, you have served on the boards of most of the health and welfare agencies in Middlefield at one time or another, and you are confident that you are an influential community leader *who knows what is best* for Middlefield. You are particularly *incensed* about the inadequate programs for child abuse and neglect in Middlefield because the prominent young businessman who was exposed as an abusive parent in the *Middlefield News* recently was a very close friend of yours. In short, you want *action, fast,* and *on your terms!*

Bias To Be Expressed:

As President of the Mental Health Association, you know from experience that *professionals "shape up"* and programs improve when they are actively *monitored* by and *held accountable to* citizen nonprofessionals. You point this out to the Task Force *emphatically* and repeatedly. You have tried to get a handle on the problem of child abuse and neglect by reading the protective services annual report, but it really doesn't tell you how much service is provided to all those statistics *nor what the long-term outcomes are*. The child protective services supervisor has assured you the agency is doing its job, but you aren't at all convinced.

Furthermore, you think programs for *prevention* and *community education* to facilitate outreach and early intervention are *very important* and beyond the scope of child protective services.

Recommendation:

You recommend formation of a Middlefield *Child Protection Council* including professionals representing Child Protective Services and other family-serving programs and an equal number of *concerned citizens.* The Council would *monitor* Child Protective Service activities and *demand coordination* with other public and private resources. It would also do comprehensive program planning for child abuse and neglect. The new money should be utilized to develop this concept and fund a *program cordinator's position.*

In addition, your concern about prevention prompts you to recommend *expanding* the popular *parent education* classes, developed last year by the Mental Health Association. You also recommend that some of the new money should be given to the *Mental Health Association* for this purpose.

You note somewhere along the line that you would be willing to *donate* the services of your public relations firm to run a *public awareness campaign* in Middlefield if your recommendations are approved.

PLANNING FEDERATION DIRECTOR ROLE PROFILE

Pat Fox—Task Force Chairperson

Personality:

You are a *seasoned chairperson*, accustomed to keeping a group *focused* on a task but mindful of the importance of getting *all participants' views* and recommendations out on the table. Thus, you do not preside with a heavy hand, but rather promote the *free exchange* of ideas, letting the participants talk and interact at will, unless you need to intervene to restore order. You will interject the Planning Federation's bias *only as a guide* rather than a mandate in formulating the Task Force's thinking and final recommendation.

Bias To Be Expressed:

Child abuse and neglect is not an area in which you have expertise, and you have no strong feelings about specific ways Middlefield should use the new money. However, your experience as Director of the Planning Federation leads you to believe that, as with most other health and welfare problems, Middlefield could best impact on this problem through *coordinated public and private agency efforts* under the leadership of several of Middlefield's *most esteemed* professionals *and* citizens.

You also believe that a *comprehensive program* is necessary, including components for: 1) Identification and Assessment, 2) Long-Term Treatment, 3) Prevention and Community Education.

You point out that both the State and the Planning Federation have stipulated that the availability of the new money probably depends on whether Middlefield can evolve such a comprehensive program.

You should communicate your bias that protective services has an important role in a comprehensive program for Middlefield, *but not necessarily* the lead role for a comprehensive program.

Your Task:

Open the meeting by welcoming the Task Force members and asking them to introduce themselves and their agency or organization affiliation. Then briefly note that the charge to the Task Force is to determine how Middlefield can more effectively respond to the seemingly increasing problem of child abuse and neglect and how a small amount of new money which may be available from the state and/or Planning Federation for child abuse and neglect can best be utilized. Do *not* get hung up in the amount of money. Take the position that service coordination can be improved even *without* new money, although the money is a conspicuous and inviting carrot. *If pressed,* suggest the possibility of a total amount between $15,000-$30,000.

Keep the meeting moving, reminding the Task Force members that *time is short* and a conclusion must be reached at today's meeting. The Task Force report will then be immediately forwarded to the State and the Planning Federation.

Your Recommendation:

As chairperson, you have no specific recommendation except to reach a conclusion agreeable to all the Task Force members today.

You do express the bias above as it seems appropriate.

PEDIATRICIAN ROLE-OBSERVER GUIDE

- What medical biases are apparent?
- Is the foundation or rationale for the bias expressed? Implied?
- Does the doctor show much interest in the Task Force? Why?
- What does the doctor value?
- Is the doctor an effective participant in the mutual decision-making process? Why?
- What does the doctor reveal about medical education?

CHILD PROTECTIVE SERVICES SUPERVISOR ROLE-OBSERVER GUIDE

- What values does this social worker profess, and does Chris Stein suggest these are unique to social workers?
- What does Chris Stein reveal about the job of child protective services?
- Is the child protective services supervisor resistant to linkage with other professional and community groups? Why?
- Is the supervisor an effective or ineffective participant in the mutual decision-making process? Why?
- How does Chris Stein respond to others' suggestions? Why?

JUVENILE COURT JUDGE ROLE-OBSERVER GUIDE

- What does the judge value?
- What does the judge expect from social workers? Is this reasonable?
- Where does the judge think new money should be allocated? Why would a Judge be likely to come to these conclusions?
- What motivates the judge's participation?

JUNIOR WOMEN'S CLUB PRESIDENT ROLE-OBSERVER GUIDE

- What is unique about Wanda Clark's recommendation?
- Is Wanda supportive of Protective Services? Why?
- How do the professionals react to Wanda?
- How does Wanda perceive the needs of abusive parents? How can these needs be met?

MENTAL HEALTH ASSOCIATION PRESIDENT ROLE-OBSERVER GUIDE

- What is John's recommendation and why?
- What is John's "carrot" encouraging acceptance of his recommendation?
- Does John influence the Task Force? Why?
- How does John relate to the professionals?
- How do the professionals react to John?

PLANNING FEDERATION DIRECTOR ROLE-OBSERVER GUIDE

- Does Pat Fox reveal any values?
- What are Pat Fox's priorities with respect to allocating new funds for CAN?
- Is Pat Fox's role as chairperson difficult? Why?
- How does Pat Fox describe the components of a comprehensive program for child abuse and neglect?
- Does Pat Fox clarify the difference between: 1) case management or case coordination and 2) program coordination? Would it be a chairperson's responsibility to do this?

Questionnaire For Local Planning

The following questions have been designed to help you organize your thinking if you are interested either in establishing a multidisciplinary council or in increasing the effectiveness of an existing multidisciplinary council or team. In considering each question, try to be as specific as possible.

If there is no multidisciplinary interagency council in your community:

1. Is there a need for one? Why? What do you feel would be the advantages of having one?
2. What primary functions would you have the council address?
3. What agencies do you feel should be involved at a minimum? Ideally?

Mark a (1) for those that have to be involved. Mark a (2) next to those that it would be good—but not essential—to have involved. Mark a (3) next to those agencies that would need to be involved only in referrals or other peripheral roles.

______ Department of social services
______ Police or sheriff's department
______ Juvenile probation
______ Department of Public Health
______ Public (city or county) or private hospitals
______ School district
______ Private social agencies
______ County Medical Society
______ Head Start and other preschool agencies
______ Foster care social Workers
______ Community mental health agency

3. Do you know and have a social or professional relationship with any staff or administrator at any of these agencies—particularly those marked by a (1)?
4. Have they ever expressed concern about how a particular child abuse and neglect case was handled, or about the general procedures for dealing with such cases in the community?
5. Which agencies do you feel might be amenable to discussing a multidisciplinary approach? Which do you feel might be resistant? Why?
6. What about your own agency? Would it be amenable to the idea or resistant?
7. What other resources would help you pull people together to discuss and perhaps form a multidisciplinary council for your community?
   - literature on how to organize a multidisciplinary council?
   - use of the movie, "Working Together," to show to other staff in your agency or other agencies in your community?
   - consultation with members of an existing multidisciplinary team from another community?
   - a training conference similar to this one for other staff in your agency or in other community agencies?

If there is an existing multidisciplinary council, but it is ineffective:

1. Is there a need for it? Why?
2. Are the functions it performs suitable? Should it perform other functions?*
3. Are there agencies that should be involved who are not?

______ Department of social services
______ Police or sheriff's department
______ Juvenile probation
______ Department of Public Health
______ Public (city or county) or private hospitals
______ School district
______ Private social agencies
______ County Medical Society
______ Head Start and other day care agencies
______ Foster care social workers
______ Community mental health agency

4. What would have to change for the council to become more effective?
   - The council's structure
   - The operating procedures
   - The commitment of agencies
   - Agency policies
   - The commitment of individuals
   - The staff or staffing pattern

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*(See chart next page)

- The budget
- Other (specify)

____

____

5. Are there other members who feel the way you do? Can you work with them on improving the council?

Function	Performs Now		Should Perform	
	Yes	No	Yes	No
Joint Investigation				
Case Consultation				
Case Management				
Joint Treatment				
Joint Case Preparation (Court)				
Development of Guidelines and Standards				
Community Education				
Advocacy				
Legislation				
Other (specify)________________				

POST TEST

Refer to "Pretest or Post Test" (Unit 1, pages 64-70).

Part II

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Leila Whiting, ACSW
Project Director
Child Abuse & Neglect
Training Project
National Association of Social
Workers

August, 1978

CHILD ABUSE AND NEGLECT: BUILDING SKILLS IN DEALING WITH FAMILIES

Time: 10 hours

CHILD ABUSE AND NEGLECT: BUILDING SKILLS IN DEALING WITH FAMILIES

DESCRIPTION OF UNIT:

This unit provides some basic skill-building activities, through developing increased self-awareness, as well as opportunities to develop interviewing skills. It includes: (1) methods of arriving at a decision to report suspected abuse and neglect, including looking at the feelings of the reporter which may interfere with the ability to do such reporting; (2) a further examination of the feelings of the reporter, how to deal with angry feelings and with children and adolescents; (3) additional interviewing skills and exploration of nonverbal communication; (4) exploring how cultural, sex and class biases affect perception of others and interfere with recognition of child abuse and neglect; and (5) crisis intervention skills and the need for continuous interagency, interprofessional community liaison.

GOALS:

1. To identify and develop skills and techniques in handling relationships with families who are in crisis, as well as those whose situations are chronically stressed.
2. To provide skills and techniques for helping where the presenting problem appears to be child abuse or neglect.
3. To identify within professionals feelings which interfere with the recognition and appropriate handling of situations of child abuse and neglect.
4. To develop skills in maintaining helpful contacts with families and referral agencies in the community around situations of child abuse and neglect.
5. To develop methods of recognizing how best to help a family where stress is causing serious problems which do not result in child abuse or neglect, but which are adversely affecting the child.

OBJECTIVES:

At the conclusion of this unit, participants will be able to:

1. List some feelings which frequently interfere with appropriate reporting of suspected child abuse and neglect.
2. Describe good practice in making such reports.
3. Describe some methods of dealing with anger.
4. List three factors which are important in effective interviewing.
5. Explain some of the difficulties many people have in working with children and adolescents.
6. Describe three factors which can interfere in interdisciplinary communications.
7. Describe two situations which indicate familial stress but which do not necessarily indicate child abuse or neglect.

RATIONALE:

Every child is entitled to a nurturing environment. Families are entitled and have the responsibility to provide this nurturing environment. When families, for whatever reasons, are unable to provide this nurturing environment, children may be at risk and need extra-familial protection. Under these circumstances, the State has an obligation to provide helpful services, the objectives of which are to improve the situation of the child and, if possible, the family as well. The underlying philosophy of this unit is that skills are necessary to provide this help and that frequently impediments to being skillful are the feelings in both the identified family and in the reporter. These feelings about the family may be related to child abuse and neglect as well as to difficulties in handling anger, authority, and class, sex and racial differences. It is only as the interfering feelings are acknowledged and handled that skills can be used effectively.

ADDITIONAL STAFF NEEDED:

None.

Activities 1-3	3 hours	Introduction; deciding to report; how and when to discuss this with the parents.
Activities 4 and 5	2 hours	The feelings of the reporter, handling anger; interviewing children and adolescents.
Activities 6 and 7	1½ hours	Self-awareness; additional interviewing skills.
Activity 8	1½ hours	How cultural, sex and class biases affect perception and handling interpersonal relationships.
Activities 9 and 10	1½ hours	Community liaison and followup; crisis intervention. Wrap-up and evaluation.

ACTIVITY	TIME	MATERIALS
1. Introduction to unit; overview; goals; group composition; trainee expectations.	25 minutes	Easel pad and markers; or blackboard and chalk.
2. Leader Presentation: "Importance of Feelings in Child Abuse and Neglect Situations." Group discussion. Presentation of "Attentive Listening." Group exercise: "Attentive Listening." Discussion. "On Being Self-Aware" (group reading).	1 hour 5 minutes	Notes; easel pad or blackboard. Resource Paper I.
BREAK		
3. Leader Presentation; group reading: "When Wonder Becomes Suspicion." Group discussion. Role-play interview with parents. Group discussion and summing up.	1 hour 30 minutes	Notes; Resource Paper II and role profiles in Resource Packet.
4. Interviewing angry families. Interview with passive mother. Group discussion.	55 minutes	Notes; script of interview (in resource materials).
5. Interviewing Children. Leader Presentation; group exercise: "Interviewing a Child." Group discussion. Leader presentation on adolescents; read resource paper; role-play interviewing adolescents. Discussion.	1 hour 5 minutes	Notes; role profiles and resource papers in resource materials.
BREAK		
6. Interviewing in child protective matters. Leader Presentation; group reading; discussion.	30 minutes	Notes; Resource Paper in resource materials.
7. Handling anger, learning supportive techniques and compilation of useful phrases; group exercise.	1 hour	Transcript of tape in resource materials.
8. Cultural, class, sex and ethnic biases. Leader presentation. Social Distance Effects. Small group game exercise; group discussion.	2 hours	Notes; Bias Simulation Game in resource materials.
9. Leader Presentation: "Community Liaison." Discussion; group reading.	45 minutes	Notes; Resource Paper II in resource materials.
10. "Crisis Intervention"; Leader Presentation; group reading; discussion. Wrap-up Summary and evaluation completion.	45 minutes	Notes; Resource Paper V in resource materials; evaluations.

SPACE REQUIREMENTS:

One room large enough to accommodate the total group and with enough space to accommodate small groups; or additional small rooms nearby available for small group activities. The large room should have comfortable chairs which can be moved into dyad positions or small groupings.

EQUIPMENT:

1 large easel, pad of easel paper and felt-tipped marker; or large blackboard chalk, and eraser.

BEFORE YOU BEGIN:

Reproduce sufficient quantities of the handout resource materials.

PARTICIPANTS' MATERIALS:

Complete set of resource materials and role profiles.

LEADER PREPARATION

This material has been prepared with an attempt to make it as self-sufficient as possible. However, in order for it to be effective as a training tool, the leader must possess certain essential characteristics. These include the following:

1. KNOWLEDGE OF AND CLINICAL PRACTICE SKILLS IN CHILD ABUSE AND NEGLECT.

It is only possible to teach interviewing techniques if the leader has developed skills in this area; and the particular stringencies of child abuse and neglect situations make familiarity with this field an equally important characteristic. Participants quickly lose confidence in, and in reality can learn little from, the instructor who lacks experience in either of these two areas. Throughout the material, the participants may express concerns about the difficulty in handling dependency needs of the families with which they work. The leader must be prepared to handle these concerns also.

2. KNOWLEDGE OF GROUP DYNAMICS.

Learning takes place as a result of the relationship between the teacher and the student, whether in an individual or a group situation. The instructor must be aware of the group's dynamics, and know how to use these to maximize the learning experience; otherwise, the result may be a minimal amount of learning, in spite of the quality of the material used and the leader's knowledge.

3. TRAINING EXPERIENCE.

Although every inexperienced leader has to teach in order to achieve experience, this particular curriculum is too sensitive an area on which to practice.

4. ORGANIZATIONAL SKILLS.

The successful completion of a workshop involves adequate planning and careful attention to detail. If this is missing, then the leader has a difficult task in training, as the resultant problems will have to be handled with the training group, thus detracting from the primary training purpose.

5. THE AUDIENCE.

Since child abuse, neglect and sexual abuse are so widespread in our society, there is a strong probability that in any given audience, there will be adults who experienced abuse, neglect, or sexual abuse as children; or who are currently abusing or neglecting their children. The leader must keep this in mind while presenting the training.

This material has been found in field-testing to be useful and helpful to participants covering a broad spectrum of experience and training. Those with little or no background in formal interviewing training find much of the material new; some of those with many years of clinical experience have commented that it has put their knowledge into a new perspective and served the useful function of a "refresher" course.

ACTIVITIES

ACTIVITY 1. INTRODUCTION, OVERVIEW AND GOALS

25 MINUTES

15 minutes
Introduce unit goals

The leader introduces this unit by stating its goals. [Optional: write on chalkboard or easel pad prior to starting and go over them with group.]

Goals

Increase skills

(1) To increase skills in dealing with families where child abuse or neglect is suspected.

Deciding

  (a) How to decide if there is "reason to believe" or suspect child abuse/neglect.

Reporting
Feelings

  (b) When to report this suspicion.
  (c) Becoming aware of one's own feelings.
  (d) How to talk with the family about the need to report.
  (e) How to talk with the child about the need to report.
  (f) Handling the family's anger, fear, or other feelings.

Interviewing skills

(2) Interviewing skills development, including the following:
  (a) Self-awareness
  (b) Listening
  (c) Observing
  (d) Reacting
  (e) Probing, and
  (f) Nonverbal communication.

Biases

(3) Development of skills in recognizing one's own cultural, racial, sex, and class biases by use of simulation exercises.

Crisis intervention

(4) Crisis intervention skills, as they differ from (2) above.

Community liaison

(5) Skills in how to follow up with a family, maintain liaison with community agencies, advocate appropriately for client services, and maintain a helpful relationship with the family.

GROUP COMPOSITION AND EXPECTATIONS

10 minutes

The leader here can use any of a number of procedures to inquire about the make-up of the group, any "getting-to-know-you" devices which are comfortable to use, or which have been proven effective. For example, you might have the audience turn to their neighbor, in twos and threes, and talk for 3-5 minutes with each other on the topic, "Why I am interested in the subject of child abuse and neglect." With a large group, the leader may just get a show of hands of what groups are represented, e.g., social work, psychology, court workers.

Expectations and needs assessment

What are trainees' expectations? The leader here can do any of a number of needs assessment exercises, asking group members to share what they hope to get out of the workshop; to write down expectations and keep that list themselves; to break up into small groups, write expectations on newsprint, then tape them all on the wall; or have group share with leader what they hope to get and leader writes these on easel pad or board. Following this elicitation of expectations, the leader must address needs which cannot be met by this training, pointing out their validity but delineating the limitations of this particular experience.

ACTIVITY 2. LEADER PRESENTATION AND DISCUSSION: "Importance of Feelings"

1 hour 5 minutes

Introduce need for
Feelings
How to handle anger

When handling cases of suspected child abuse and neglect, it is of paramount importance to understand your own feelings both about the whole situation and about the particular family with which you are dealing. For example, you may feel angry and punitive toward a parent for hurting a child. You may, however, have learned that in order to be helpful, you must be accepting of the other person; as a result, you may feel that your anger and wish to punish are unacceptable and so you repress them. The result may be a fake heartiness or a superficial friendliness when dealing with the parents. They will spot this as quickly as any of us would, and they, in turn, will be put off and, despite your conscious attempts, they will feel unaccepted.

Some examples of how to handle anger

You might say, "What then: should I tell them I am angry and critical?" Obviously, that is not useful either. However, you can acknowledge your feelings to yourself. If you can talk to a supportive colleague or supervisor, try that. If that's not available, at least say to yourself something like this: "I know I am angry that this child was hurt; but I also know I want this family to get help. So, knowing I am angry, I will try to understand what has been going on. They expect anger and rejection—so even though that's how I feel, I won't take it out on the parents."

This kind of self-awareness can get you through the first contacts in better shape than either an immediate confrontation with the family, or the false friendliness which can feel like rejection to them.

Examples of feelings
Write them on easel
Assess danger
Self-protection

Reporting child abuse or neglect always arouses some feelings in the reporter. [Leader: Ask group for examples of feelings they have had in this situation, or think they would have. Write these on blackboard or easel pad. Ask for suggestions as to how these have been successfully handled. Comment positively on the efficacy of each method and point out the lacks, better methods, etc.] Often, reporters are anxious that if the child was hurt by a parent, perhaps the parent will hurt them too. If you are truly very fearful for your physical safety, make sure you are protected. Don't be in a building alone, for example; make sure someone else knows of your interview. If you are really frightened, have someone else in the interview with you—a colleague, supervisor—not as a bodyguard, but to share with you the process of talking with the family.

Use of police

If you are a child protective worker and think the situation in a home visit may be dangerous, make sure you request a police accompaniment. If the police go with you, be prepared for their usual methods of investigation, including frisking the family about whom a report has been made. If you are a police officer, be prepared for the child protective worker to be more concerned with attempts at rehabilitation than with pursuing evidence of criminal activity. Also, the police officers may see evidence of a more serious crime and pursue that investigation, such as drug possession. Child protective workers decide when to ask for police to accompany them based on such things as history of family violence; others' knowledge of risk; case records and/or history; family's refusal to admit them on first home visit.

Meaning of avoidance
Don't forget, the report may be found to be "invalid" and you may thus continue to have primary responsibility to work with the family

Another feeling which may interfere with effective handling is a wish to avoid the issue altogether. The family may make excuses about changing appointments, not keeping ones made already, etc. Because of your wish to avoid the issue, you may "buy" the excuses and not inquire further as to their reality. It must be remembered that if avoidance is what you are feeling, so is the family! If embarrassment is what you are feeling, so is the family! If you are angry, so are they. Are you upset? They are too. Your feelings will almost always tell you something about what is going on in the client. So use your feelings to give you clues about them. But you can only do this if you are *aware* of and *in touch* with them.

LEADER PRESENTATION: "Attentive Listening"

10 minutes
Interviewing skills: listening

In dealing with families, and in knowing how to respond to them, one of the most important skills to learn is how to listen. You need to hear not only what the person is saying, but you also need to understand what (s)he really means. (S)he, in turn, needs to experience you as an interested, understanding person. Your nonverbal communication must convey this, as well as your verbal communication.

Observing
Nonbiased listening

You will need to observe and to interpret your observations, and use these to further your understanding of the total situation. Often when we talk with someone in order to get or give information (that is, "interview" them), we feel we must always respond, answer questions, provide information, explain our actions. Although all of this may be necessary from time to time, sometimes what is most necessary is to be able to listen and truly *hear.* We must be able to listen nonjudgmentally; that is, without sharing our views, or biases, or criticisms, or approvals.

Criticism is often perceived
Suggested comments

People often need encouragement to talk to us in an honest and open fashion. Criticism, either directly or indirectly, will stop the flow of open communication and has no place in an information-gathering or -giving interview. You must be exceedingly careful also about how you give approval as it is often heard as implicit criticism, or else it is experienced as "phony," as if you were trying to make someone feel better by saying hearty, encouraging things which are not true or have no meaning. People who have low self-esteem often have a distorted perception of comments made to them. For example, telling a woman who has obviously just been to the beauty parlor that her hair looks nice may be heard by her as implying that yesterday her hair looked awful. To say nothing at all may be perceived as ignoring her, or not paying enough attention to notice. You may be damned if you do and damned if you don't! The best way is to make an observational comment, such as, "I notice your hair is different," or "It looks like you've been to the beauty parlor."

Importance of objectivity

How can we convey interest? One way is by attentive listening. This may involve maintaining eye contact with the person who is talking. What if they evade your eyes? What if they turn away, look around the room, behave in what is often seen as a "shifty" fashion? In some cultures this is appropriate and proper behavior. Make a note of this in your own mind. Sometimes people may feel uncomfortable with authority. We often think this means the person is lying. This may be so, but it equally may not be so. There are often many reasons for people not to maintain eye contact, but despite what the other person is doing, the interviewer must make mental notes.

Another way to convey interest is by body posture. Leaning back in your chair and crossing your arms in front of your chest conveys a different meaning from leaning forward with your hands lightly clasped in your lap. Think about the meaning of body posture. Observe how your client is holding his or her body, and see what response you feel like making. The person who shifts the chair to be sideways to you, instead of facing you, or the person who repetitively kicks a leg, makes you feel different from the person who moves too close and breathes down your neck. Observe the client and note the reaction you have. That will be an important clue about the other person.

Nonverbal communication
Observe and note

When people succeed in making you feel "put off" in some fashion, it is usually because they unconsciously expect that to happen, and by their behavior, they actually make it happen.

GROUP EXERCISE: "Attentive Listening"

10 minutes
Practice: "Attentive Listening"
Participants choose partners for exercise
Give instructions

In this exercise, you are to each choose a partner next to you or nearby. Decide who will be A and who will be B. (Leader: Instruct the group to find partners.) First, A will talk and B will listen (on a topic I will give you in a moment). Then, after about 3 minutes, you will switch roles. Then I will give you another topic to talk about, and B will talk and A will listen and you will again switch roles. Turn your chairs so A and B are facing each other. The listener is to maintain fairly good eye contact with the talker, regardless of what the talker does. The listener is to *listen*, and the only talk the listener is to do is this: if you do not understand what the talker said, you may ask a question, but only for *clarification*. [Leader: Discuss any questions the group may have, and *repeat* instructions for "how to listen."]

Refer group to p. 320 in this unit.

Change roles

The first topic to talk about is: [Leader may choose any of these in any order but only give one at a time. At the end of three minutes, or when the talk is beginning to die down, stop them and have them switch roles. After another 3 minutes assign a new topic as A and B change roles from listeners to talkers and vice versa. Leader may need to remind group of listeners' instructions.]

Choose one topic at a time

Topics:

(a) When you were a child, how could you tell when a parent was angry?
(b) How can you tell when you are angry?
(c) How do you express or handle your anger in different situations?
(d) How do other people who are close to you know when you are angry today in various situations?
(e) How do other people act when you are angry?

Conduct discussion

At the end of this activity (approximately 10–15 minutes), have the group report on: (a) how it felt to be listened to without verbal responses and (b) how it felt to listen without verbally responding. Ask what they learned from the exercise.

10 minutes
Read Resource Paper
Conduct discussion

"On Being Self-Aware"

Leader: Request group to turn to Resource Paper I on p.113 in their resource material. Tell them to read this material. When most of the group seems finished, start a discussion by asking for any comments, questions or thoughts stimulated by the paper.

1 hour 30 minutes

Suspicion is reportable

ACTIVITY 3. LEADER PRESENTATION: "When Wonder Becomes Suspicion"

State child abuse reporting laws require that when someone working with a child "suspects" child abuse, this must be reported to the appropriate authorities. Sometimes the words are: "has reason to believe" or "has reasonable cause to believe." There seems, in the law, to be no room for the observer to sort out the facts, to exercise judgment. The law says that when you suspect, you must report. The problem for the reporter often is in the definition of the word "suspect."

What is suspicion?
"Wondering"

When we are aware that the phenomenon of child abuse or neglect exists, it takes its place in our minds as something that can happen to a child, like falling off a skateboard, getting chickenpox, or having a fist-fight with another child. If we, therefore, see a child with bruises, and all of these potential or possible causes flash through our minds, are we "suspecting" child abuse within the meaning of the law? We are arbitrarily going to label this kind of "suspicion" as "wondering." The child has bruises. At this point, that is all we know. We wonder: is it a fall? a fight? child abuse?

Need to see pattern

How then, does wonder get transformed into "reason to believe" or "suspicion" of child abuse or neglect"? Clearly, some preliminary, careful and gentle inquiry is necessary as well as some thinking on our part. What do we know of this child and the family? Do we know of stresses and tensions? Is there a pattern to the child appearing with bruises? What is the child's explanation to a casual inquiry of interest? Is there a pattern to a neglectful situation? How long does this pattern go on before we decide to report? At the point that wonder gives way to suspicion, that is when reporting must be accomplished.

Read Resource Paper
Conduct discussion

(Leader: Instruct the group to read Resource Paper on p. 115 of the resource material. When most of the group seems finished, conduct discussion. Encourage the group to be specific in their comments and questions. Many things on the checklist are more important than others. How many are based on clinical experience and not research? Ask the group to produce or brainstorm a checklist for neglect.)

ROLE-PLAY INTERVIEW WITH PARENTS

45 minutes
Usefulness of informing parents of report

Having decided to report a situation of child abuse or neglect, the next step is to talk with the family about the need to report and to prepare them for what may happen. When this is suggested to people, the first response is often, "Oh no! How can I tell them? I'll just make the call; the child protective worker will tell them."

Reluctance to inform family

This is a very common response, and it is usually based on the reporter's feelings of discomfort in facing someone else and telling them something unpleasant. It is *something* like our reluctance to report on a cheater, to tell someone he or she has a terminal illness, to say "no" to a pleading request. Sometimes we are fearful that the family will hate us, and for most of us, that is a powerful deterrent. But it is important for the family to know that you have noticed and observed their child, the behavior, the physical condition, and that you are sufficiently concerned about them to suspect that all is not well in the family; and that having noticed this, and reported it, you are still willing to work with them, and do not reject them out of hand.

Share need to report with the family

It is good practice, wherever feasible, for professionals to inform the family that a report has been made or is going to be made. This facilitates the child protective service job of investigation since the family knows who made the report and does not get diverted into trying to find out where the report came from. It also treats them with respect and openness and gives a message of your positive regard.

When NOT to share need to report with family

There are some situations in which clearly it is *not* feasible to tell the family about your report. For example: where a parent is psychotic, or has a history of violence outside of the family, or where the parents may abscond with the child or where a medical emergency exists and the primary task is medical care for an injured child. But most situations reported (whether of child abuse or neglect) are chronic ones, and these are the ones where it is good practice (although many find this a difficult task) to share with the family the legal requirement for you to report.

REMEMBER:

Instruct group in role-play; divide group
Refer to role profiles in Resource Materials
Continue role-play

No parent wants to be a failure as a parent! [Leader: Divide the entire training group up into smaller groups of 5–15 persons. Tell them which corners of the room to go to, or which other rooms they are to go to. Show them the role profiles on pp. 324-325 and 327 in this unit. Point out to the total group that this is a skills-building exercise and each will have an opportunity to role-play different situations. There are no right or wrong answers, and participants are to try to be aware at all times of what they are feeling, while they are role-playing the parents as well as the reporter. Explain that the role-play instructions indicate how they should react rather than give specific background. Participants should fill in the background however they wish, either from a case they know or from their imaginations. Explain to the group that the objective of the role-play is for the professional to tell the parent(s) that a report to child protective services will be made. The observers are to feel free to offer comments. The role-play is to be brief and they should stop themselves if they complete the task; *or* if they feel "stuck" they should be encouraged to ask each other how they were feeling. Encourage the small groups to "stop the action" if they feel the players are going far afield. Many participants find it *very* difficult to do this exercise and they may need a lot of encouragement and support from you to understand how their feelings are interfering with the successful completion of this task. It is surprisingly difficult to tell people negative things in a calm and factual manner. Instruct the group to return to the main room at a specific time, 30 minutes later.

DISCUSSION OF ROLE-PLAY

15 minutes
Conduct discussion of role-play

Following the role-play, reconvene the entire group and discuss those factors which were difficult and those which were facilitative. Ask the group to share how it *felt* to be the professional. Make sure those who role-played the parents get an opportunity to talk about how being the parents felt to them.

Sum up

Summarize the activities to this point.

ACTIVITY 4. INTERVIEWING ANGRY FAMILIES

55 minutes
5 minutes
Tying together

[Leader: Spend a few minutes summing up the previous activities, highlighting some of the problems which surfaced. Probably dealing with anger will be one of these; if not, mention it as a common problem and thus lead into the next activity.]

Leader Presentation: "Interviewing Angry Families"

15 minutes

Anger hard to deal with
Reactions to anger

All emotions present certain difficulties to us when dealing with other people. But anger is probably the most difficult of all with which to deal. When others get angry at us, we have different reactions, depending on our own backgrounds and experiences, the present situation, and how we perceive what is going on around us. One common reaction to anger is anger. Someone gets mad at us and we often retaliate with anger. Another common reaction is fear and a wish to avoid the situation; we almost always wish to calm down and defuse the anger. Appeasement is often used for this purpose.

Need to be in touch with our own feelings in order to react helpfully

Whatever our reaction to anger, two things are essential if we are to handle the angry person effectively. First, we must be aware of our own feelings and know that almost always they will also reflect how the other person is feeling. That is, if we are frightened, probably the other person is frightened; if we feel in a panic, probably that is how the other person feels, and so on. Secondly, we must be able to utilize this knowledge of how we and the other person feel in order to be helpful. That is, we must be able to say something constructive when other persons are angry which will defuse the anger and help them hear what we need to tell them.

How to handle anger

Probably the least useful thing to say to an angry person is: "Calm down! Calm down!" The next least useful thing is to shout them down with our own anger in a bullying fashion. Most helpful is to acknowledge how the other person must be feeling. Most of our anger evaporates when we feel *understood.* [Leader: give some examples of this, or involve group in giving examples.]

DIALOGUE: "Interviewing the Angry Mother"

20 minutes

We are going to listen now to a dialogue of an actual interview with a client. [Leader: Ask for a volunteer to read the part of Connie Peterson, the school nurse. You may read the part of Mrs. Hunt, or you may have another volunteer read Mrs. Hunt's part. Introduce the dialogue by reading the following introduction.] Interview with angry mother.

SCRIPT OF INTERVIEW

Introduction

Julie Hunt is a third-grader who has been consistently late for school and appears to be tired, hungry, and inadequately clothed when she gets there. Connie Peterson, the school nurse, has met with Julie's teacher and the school principal to discuss the situation. They decided that they should try to reach Mrs. Hunt and inform her of the school's observations. She has not responded to letters, so the plan is for the school nurse to visit the home. They believe that a referral to child protective services may be in order, and the school nurse is to decide, after talking with Mrs. Hunt, whether this is the case. If such a referral is appropriate, she will inform Mrs.

Hunt of the plan to do so. She has written, explaining that she will visit the home, telling the exact date and time that she will be there. We will now role-play this visit for you.

Interview

The nurse, Connie Peterson, has arrived at the door and she knocks. There is no answer; she waits and then knocks again.

Mrs. H: Who's there?

Nurse: I'm Connie Peterson, from Fifth Elementary School. I'm looking for Julie Hunt's mother. I would like to talk with her.

Mrs. H: What do you want with Julie Hunt's mother?

Nurse: I would like to talk with her a little bit about Julie. I did write a letter, explaining that I would be visiting today. Are you Mrs. Hunt?

Mrs. H: Yes, just a minute, I'll open the door. What is it?

Nurse: I'd like to come in and talk with you, Mrs. Hunt, if I may.

Mrs. H: Come on in . . . have a seat.

Nurse: Thank you. Did you receive our letter?

Mrs. H: Yes.

Nurse: Well, as we explained very briefly in the letter, we've been very concerned about Julie at school, first of all, because she has come to school quite late every day.

Mrs. H: Sometimes Julie watches TV at night and I feel that's sometimes why she's late.

Nurse: Yes, well, then, what you are saying is that she is staying up too late and not able to get up in the morning?

Mrs. H: No, that's not what I'm saying; I'm sayin' that she watches TV sometimes and that she stays up late.

Nurse: Okay . . . Umm . . . are there any other ideas that you have about her being late for school?

Mrs. H: No, not really.

Nurse: Well, we are concerned about that, as I said, and we also have noticed that when she gets to school, she is tired, and puts her head down on the desk, sometimes falling asleep, unable to do her lessons. Has Julie seemed tired to you when she is at home?

Mrs. H: No.

Nurse: So this just seems to be a problem when she gets to school. Furthermore . . . Umm . . . this is still another thing . . . she is very hungry during lunch time, frequently taking the food from other children's trays, after she has eaten her own very rapidly.

Mrs. H: Are you saying that she doesn't get enough to eat?

Nurse: It certainly appears that she doesn't have enough to eat, that's the way she acts when she's at school. Have you any experience with that at home, Mrs. Hunt?

Mrs. H: Well, she usually eats quite a bit at home. I don't know why she is eating other people's lunches and I will talk to her about it.

Nurse: Have you had her checked by her doctor recently?

Mrs. H: No, we don't have a doctor.

Nurse: I see . . . I've looked at her records at school and I noticed that there is a weight loss instead of a weight gain, which seems unusual when she is eating so much.

Mrs. H: You mean that she's sick?

Nurse: I'm wondering if something may be wrong and if she should be checked. Perhaps that's something that you could be helped with, finding a doctor that you could take her to.

Mrs. H: Well, I don't really need any help. If I want to find a doctor, I will; but, is it your opinion that she is sick?

Nurse: I would suggest that Julie be seen by a doctor, to see if there can be some explanation for her hunger and for her weight loss. If she continues to lose weight the way she has, I do believe she will be sick.

Mrs. H: Then I will find a doctor to take her to.

Nurse: Good, because I think she really needs that and I'm glad that you can do that. Another problem, Mrs. Hunt, and I hope I'm not over-loading you with problems this morning, but as long as I'm here, I need to talk with you about all the things that we've noticed and that is that Julie is showing up at school in this cold weather without a coat on, or any kind of sweater.

Mrs. H: Julie has a coat and if she chooses not to wear it, then I feel like it's up to Julie, because she's a sensible child and she knows when to put a coat on.

Nurse: I see . . . you really don't feel that there is anything that you want to do about that . . . is that what you're saying?

Mrs. H: No, because I feel that Julie is old enough to know how to put her coat on, and she does have one.

Nurse: Okay. (Long pause) Do you feel that on the basis of what I have told you, Mrs. Hunt, that there are any changes that you can make in the situation that might improve the things that we observe at school?

Mrs. H: No. I don't see that there is anything that I can do, other than listen to you talk about what Julie needs.

Nurse: Then I think what we need to do now is make a referral to child protective services.

Mrs. H: Who is child protective services?

Nurse: It's an agency in town, an agency that has social workers on the staff who are trained to work with parents and talk with them about the things that their children need and about things that the parents might need themselves and need help with. What they do is they make a visit to the home, and will discuss the things in more detail than I have brought up with you this morning, in terms of how they view it, and in terms of how you view it, to see if something can be worked out to help Julie get to school on time more regularly and also to help her be less tired when she gets there.

Mrs. H: Well, I don't really want to be bothered with social workers or with people who will be interfering in my personal business and I think that you can refer me, but I won't go.

Nurse: I understand how you feel. I think that it is hard to have people interfere when you don't feel any need to have them do so. I think that at this point, it sounds like the school is more concerned about what is happening to Julie and you feel that things are okay. They will come to your home, as I said, and visit you there. In fact, I'm going to call a worker that I know. Her name is Georgia King, and she has worked with a number of parents who have been in the same situation as you . . . in other words, parents who haven't particularly wanted to see her any more than you want to. And they tell me that they end up liking her . . . that she is easy to have, to visit.

Mrs. H: Why do you want to do this to me?

Nurse: As I said, we are concerned about what's happening with Julie at school and I see that you see things differently from the way that we see them. We think that something needs to be done about it. And child protective services is in a position to help you do that, or at least to decide whether or not they need to help you do that.

Mrs. H: And what if I decide not to go to child protective services, then what?

Nurse: They will come and see you and it is up to them to decide, on the basis of our talking with them, whether they must insist on seeing you, Mrs. Hunt. It is not up to us. But if they decide that they absolutely must see you, then they can obtain a court order to do so. I can see that you are feeling very discouraged and very upset about this referral.

Mrs. H: Yes, I am, because court order or no court order, I don't feel like I want a lot of people interfering with my life and interfering with Julie. I think that we have problems, but who doesn't?

Nurse: I agree, I feel the same way myself, that it is difficult to have people intervene or interfere in one's life and it's true . . . I know, I have children myself and I have problems with my children, too. It is when the problems one has with one's children are being noticed in the community somehow, as they are in school, that there is a possibility of intervention, of outsiders coming in to see you, whether you wish to be seen or not.

Mrs. H: Well, that remains to be seen and I really would like to stop talking now, because I really have had enough. Let's just stop now.

Nurse: Okay, you know, I have an idea, if you have some time right now, and if you are willing to try it out, and that is, that since you don't have a telephone here, that you come back to my office with me, I will drive you back with me and bring you back home again, by the way, so that you can be in my office and you can hear what I have to say to Georgia when I call her. That way, you will know what she knows about you when you see her and also you can talk directly with her to find out what is a convenient time for you to get together.

Mrs. H: You will take me, even though I said I will not talk to her?

Nurse: As I said, I will make the referral, even though it's against your wishes. I need to do that. I am required by law to do that and I think that it might be easier for you if you heard her voice and had some chance to get a sense of who she is and what you might talk to each other about. Otherwise, we can leave it that she will just make an appointment with you and come to your door. If you would rather do that, we can work it that way too.

Mrs. H: Well, I'd rather you did that, because I really don't want to talk to you anymore.

Discussion Questions After Dialogue

Conduct group discussion

(Asking for responses from the group.)
Was this mother angry?
Did the mother see the report as a threat?
What else could the nurse have said?
Should the nurse have discussed possible consequences?
Who was most uncomfortable in the situation?
If the mother agreed or offered to correct the situation, would you still report?
How does the hostile parent manage to make you apologetic?

Important for parents to feel in control

Note: The interviewer was careful to have mother come out a "winner" which ensures greater safety for the child. Discuss and explain how leaving the parent in control of even a small part of the situation makes her feel less "cornered," and therefore less likely to explode at the child. Point out how interviewer here created this option for the mother.

ACTIVITY 5. LEADER PRESENTATION: "Interviewing Children"

1 hour 5 minutes

10 minutes
Desire to avoid pain

Talking to children is something we all do. Understanding their communications to us is something we all attempt, from the baby who is crying to the adolescent who refuses to talk. It is important when dealing with children to be open and honest. If we don't know something, say so. We have a tendency to want to make everything "right," to make the uncomfortable comfortable, to take away the pain. Be realistic. Some situations are painful. You did not create the painful situation for the child, but you may be in the position of identifying it. Children often respond to stressful situations by asking questions, an attempt to make the situation more manageable. Try to identify the feeling the child has that led him to ask that particular question. Sometimes questions need clear straightforward answers; sometimes they need understanding.

Need to talk to child

All too often we ignore children after deciding to report a suspicion of child abuse or neglect. It is important to let children know what may happen.

GROUP EXERCISE: INTERVIEWING A CHILD

10 minutes
Group exercise

The group is to divide into pairs again—can be the same partner as in the Attentive Listening exercise or not; it does not matter. Decide who will be A, who will be B. *A* will be the adult to start with. The "child" can respond as needed. I will describe the situation, and the person role-playing the child should take a moment to think how to respond.

Instruct group in exercise: "Interviewing a Child"
Conduct exercise

B is an eight-year-old. A has decided that there is reason to suspect abuse. A is going to phone in a report of suspected abuse, and is telling B that is what is about to happen. A is to be straightforward about the concern for the child, but be careful not to make it sound like an invitation to a Christmas party. Let the child experience his own discomfort, pain, fear, etc. but be clear that you have not created the situation, only spotted it. Three to five minutes will be alloted for each role play. At the end of the first five minutes, instruct A's and B's to switch places and repeat instructions, and the introduction.

Group Discussion

5 minutes
Conduct discussion.

Leader: conduct a discussion on how it felt to be the child and how it felt to be the reporter.

LEADER PRESENTATION: "Interviewing Adolescents":

5 minutes

Resource material

[Leader: Either use notes on adolescents to construct your own presentation, or instruct participants to read the notes on p. 116 of the resource material. If you make your own presentation, be sure to tell the group of the resource material for their future reference.]

Notes on Adolescents.

Particular problems of adolescents

Adolescents present different problems, mainly because they are seen by adults as being more like adults and therefore more reasonable, but at the same time, they are regarded as still children and therefore to be treated as such. Adolescents often present themselves in the same confused fashion. Often adult-sized, they are frequently uncomfortable in their new bodies; given adult privileges like driving automobiles, they frequently both accept the responsibility and at the same time act like irresponsible children, using their privileges in a fashion that is the despair of their parents and teachers.

Mood Swings
Low self-esteem

Even the well-adjusted adolescent presents paradoxes of mood swings, of seeming one day like a mature adult, the next like a kindergartener. Children who have been abused and neglected have very negative self-concepts, very low self-esteem, are very unsure of themselves and particularly, they are unsure of their acceptability as people. The defensive shields which they erect to protect this painful inner self varies from straightforward hostility to silent withdrawal and everything in-between, including placating politeness.

Need for objectivity
Adolescents are often loyal to family
Suggested things to say

In talking with the adolescent about what has happened to him, it is important to be careful to be nonjudgmental, both twoard the child and toward the child's parents. Most children both love and feel strong loyalty toward their parents, even parents who appear to us to be cruel or harsh. It is important with the adolescent to remember that behind the sometimes brash exterior is a frightened child; therefore, never ask the adolescent who may appear with bruises or other signs of abuse, "Well, what did you do this time?" It is of equal importance not to ask, "What did your parents do to you this time?" Word your questions in a nonjudgmental, open-ended way. Avoid questions which can be answered "yes" or "no." Some examples of productive questions or comments include: "Can you tell me what happened?" or "I know that when kids get hurt there is usually something upsetting going on at home," or "I can see that you are upset and I am interested in hearing about it."

Be straightforward and honest

Handling adolescent's hostility

In telling the adolescent of your concern and the requirement that you report his injuries to the proper authorities, try to be as open about it as possible. Explain that you are concerned that family problems seem to be ending in the child getting hurt—being careful not to assign blame. Explain further that when this happens, you would want the family to get some help with the problems, and that the law requires that this be reported to protective services. Explain as much as you know about what will happen, but if you don't know, say so. It is upsetting to be expecting one thing and have something else happen. If the adolescent responds with hostility, such as, "You stick your nose in everyone's business," or "You have no right to do that!" or some other angry response, you need to stay focused on your concern for him. It may also be useful to recognize the fear that often underlies this kind of anger. You might then respond in one of the following ways: "You seem upset by what I said," or "You may wonder what will happen next," or "Many people (or kids) feel apprehensive in this situation."

Universalize feelings

Do not "read minds" or "second-guess" the adolescent. It is more useful to universalize the idea than to attribute it to the child. If you say, "I can see this scares you," or words to that effect, the child may feel overwhelmed and panicked that you could so clearly read his feelings, and may well respond with a hostile "Not me!" or "You're wrong!" By saying that "Many people in this situation feel upset, frightened, angry, etc.," you are universalizing the experience and the person is left free to say either "Maybe *they* are, but *I'm* not," or "Yeah, me too!" In either case, he does not feel you are intruding upon him, getting closer than he can at that moment tolerate. We are going to practice some of these exchanges now in small role-playing groups.

ROLE-PLAY: INTERVIEWING ADOLESCENTS.

30 minutes

Conduct role-play

Divide into groups of 5–10 (or into dyads). These may be the same or different groups from the ones previously formed. Explain to the participants that they are to assign roles as per the role-playing outlines on pp. 324-325 and 327-329 in this unit and ask the participants to take a few minutes to read their roles and think about how they will respond. There are three role-plays and they are to do them all, or choose one or two. They are to stop the role-playing when things get unfocused, and inquire as to what was going on. It is important, in helping participants develop skills, not to criticize participants for what they did, but rather to build on what they did that was good and can be improved. It is more useful for participants to understand how their own feelings and reactions blocked their effective use of themselves than for others to "point this out." Tact and supportive comments are conducive to learning. Instruct the participants that they are to return to the large group in 30 minutes.

Group Discussion of Role-Play

5 minutes
Conduct group discussion

Conduct a discussion of the difficulties and feelings evoked in this role play.

Summing Up

5 minutes
Sum up

The leader should summarize the learning opportunities already covered, and describe the subsequent activities as being ones which will cover additional interviewing skills including: observing, reacting, probing, nonverbal communication.

ACTIVITY 6. INTERVIEWING IN CHILD PROTECTIVE SITUATIONS

30 minutes

15 minutes
The involuntary client

The leader can point out some of the problems involved with interviewing the involuntary client. There are some similarities in working with children who usually are also involuntary clients. The group should be encouraged to share their perceptions of some of the difficulties encountered in involving the involuntary client in a helping process. Probation and parole workers, court workers, alcohol counselors may all have similar experiences.

Group (Silent) Reading; discussion

15 minutes
Read Resource Paper III

Instruct the group to turn to Resource Paper III on p. 117 and read this material. When the group seems almost all finished reading, start discussion by asking for questions, comments or thoughts provoked by reading the material.

ACTIVITY 7. HANDLING ANGER: COMPILATION OF USEFUL PHRASES

1 hour

Read interview script, p. 000 in Resource Materials
List useful phrases

Have the group turn to the script of the interview in the resource material.

Have participants suggest particularly useful phrases and words used by interviewer that seemed helpful. Write these on easel pad or blackboard. Ask participants to suggest phrases they have found helpful in the past, and add these to the list if they seem appropriate. If suggestions of repressive phrases, or insulting ones are brought up, ask participants to respond regarding the effect of these comments.

When list is compiled, suggest participants copy these down for possible future use.

GROUP EXERCISE: "Attentive Listening with Supportive Responses"

20 minutes

Learning supportive responses
Conduct exercise
Assign topics

Have participants find partners and assign one to be A and one to be B. As in the previous dyad exercises, they are to take turns listening and talking, utilizing some of the techniques and ideas just learned. This time the listener is to do the following: (1) observe the talker; and (2) react with comments which indicate awareness of the talker's feeling state. The listener is only to make comments that identify a feeling which the talker is expressing, or which the talker may have felt at a previous time. Just comment on the feeling. For example, "That sounds scary," "You must have been upset," "What fun," etc. Think what the feeling must have been and comment on it. After 3–5 minutes, have participants change roles and repeat instructions. Choose topics from those below. After each has talked and listened once, have each write down their observations of the talker when they were the listener. Conduct group discussion. How did the talker *feel* when the listener identified a feeling? Was this supportive? How? How did the listener *feel?* What did they both learn? What did the observations tell about the talker's state of mind?

SUGGESTED TOPICS FOR ATTENTIVE LISTENING WITH SUPPORTIVE RESPONSE

(a) When I was a child, the dinner hour was . . . .
(b) In my family now, mealtime is . . . .
(c) The way I was disciplined as a child was . . . .
(d) When I see a hurt child, I feel . . . .
(e) When children fight, parents should . . . .

LEADER PRESENTATION AND GROUP EXERCISE: "Nonverbal Communication"

15 minutes

Nonverbal communication exercises

Having tried to communicate by talking, now we are going to try some nonverbal communication.

Have the group take same partners of A and B as they had for the last activity. Have A listen and B talk, but first have A and B turn their chairs so they are back-to-back instead of face-to-face. Assign one of the topics not yet used and have B talk about it. If time allows, change roles and have A talk and B listen, still back-to-back.

Conduct discussion of how this felt to both. If there were any nonbelievers in nonverbal communication's effect on us, there should not be any left now.

Another nonverbal exercise can be done as Virginia Satir suggests in *Peoplemaking.* If you are not familiar with this work, try this one.

Describe optional nonverbal exercise

Have group form two circles and have them walk in opposite direction for a few moments. Stop them and have the two circles turn toward each other. Partners are now opposite each other. Have the people in the inner circle assume the "Blamer" position as follows:

> One hand on hip, the other straight out from the shoulder with a pointing finger aimed at outer circle partner. Head is thrust forward, face is screwed up and tight, angry; body leans forward. Eyes on eyes of partner.

Outer circle partner assumes placating position:

> Down on one knee, wobbly and unsteady, one arm across chest, the other held in a bent palm upward pleading gesture. Chin is raised high so neck is bent backward, expression is pleading, ingratiating, eyes focused on chin of partner.

Conduct discussion

Have group keep this position, if they can, for one whole minute. Have them break the position, stretch muscles and return to seats. Conduct discussion on how this *felt* to each of them, both in terms of how their own position felt and how the partner made them feel.

Conclude this activity with a group discussion on ways of communicating, the need to be aware of one's own feelings as an aid to understanding the other person, and the need to understand how we come across to other people. Summarize highlights of the learning experience to this point.

Summing Up

5 minutes

ACTIVITY 8. CULTURAL, SEX, CLASS AND ETHNIC BIASES

1½ hours

Leader Presentation of the Concept of Bias

20 minutes
Discussion of bias

Bias can mean a preference for one person over another, and may be quite conscious and deliberate, such as when one has an overt sexual preference. A bias can be more subtle and although one is somewhat aware of it, it is less deliberate. For example, some employers always choose employees who are incapable and incompetent, unconsciously wishing to avoid being "shown up" by capable workers. Other employers choose those who are capable, enjoying their stimulation and challenge. We may also be quite aware of our biases but may not want to be considered biased, since this is largely socially unacceptable. We may be biased about, and feel uncomfortable with, people who are physically handicapped.

Elicit group experiences and attitudes

[**Leader:** It is useful to elicit participants' feelings and experiences with the handicapped—these feelings are less threatening, but you will want to point out the discomfort mentioned and how the feelings are the same as in other situations where bias exists.]

Cultural differences used to excuse abuse or neglect

We are also likely to attribute characteristics and attitudes to those whose background is unfamiliar. For example, the Chicano family who is poor and living a marginal existence and whose children are abused or neglected may go without help when an "Anglo" says, "That's just the way those people live; they are used to it. Those children are not abused or neglected; that child-rearing pattern is cultural." These assumptions may or may not be true, but certainly our own unconscious biases will affect our way of relating to others.

Biases may be used as a defense

What is true for us is true for others. Many families, confronted with a professional of a different racial or ethnic background, are frightened, upset, and feel that they are not understood and may consciously or unconsciously throw up a defensive screen, while appearing not to. We are discussing here biases and cultural barriers of which the participants are not clearly aware. There are, of course, situations in which it is very obvious that cultural barriers are in the way of good communication.

Conduct Bias Simulation Game

Bias Simulation Game

Leader will now tell the participants that they will be doing a small group exercise which will help them get in touch with feelings of various kinds. The roles for this exercise begin on p. 000 of the resource materials. You can number the group off from 1–8 with as many observers in each group as you wish. Each small group member is thus assigned to the role with the number you have given. That is, number 1 becomes the "chairperson"; number 2 the YMCA youth worker, etc. Remind participants to read ONLY the Introduction and their own role profile. Strongly urge them not to peek at other profiles until the exercise is completed. Ask that when they are in their small groups that they take a few moments to think about their roles and how they will present themselves. Request that those who are observers read ONLY the Introduction, but no role profiles. Tell participants they have 30 minutes and ask them to return to the main room at the end of that period.

Optional Native American Indian roles

[**Note to Leader:** There are two optional roles of Native American Indians. If you are doing your training where there are Native American Indians, you may wish to use these roles in the game either *in addition* to the other roles, or *instead of* a role or roles (2) which are not applicable in your community.]

Conduct group discussion

After the simulation game is completed, conduct a discussion of the participants experiences. Utilize the observers' notes and observations.

Professional bias important to understand

You should find that as well as racial, cultural and ethnic biases, an outstanding block to communication and collaboration is the professional bias. Each participant has an agency or professional constituency which is usually represented with some passion. Note this with your group, as it underscores the necessity for community liaison activities and links right into ACTIVITY 9.

ACTIVITY 9. LEADER PRESENTATION: "Community Liaison"

45 minutes

Need for family advocacy

Because bureaucracies are often insensitive to the individual's needs, it becomes important for someone to humanize the resources. There are times when you may have to be the family advocate and make sure they have not had their application lost, been placed on a waiting list, been ignored.

Expectation of rejection
Passivity may be fearfulness
Anxiety often provoked by "first" situations
Need for follow up and advocacy

If the family can make the phone calls, it is useful for them to do so. You will need to assess both their motivation and their ability to be sufficiently aggressive to do so. Many abusive or neglectful families feel they are both unworthy of being helped and unhelpable. They expect rejection and failure and therefore that first step of making an initial contact may be extremely painful. Their pain may be manifested by hostile resistance, or perhaps passive resistance. They may say "Yes-yes" and do nothing. Or they may blow off some steam at you. You might keep in mind that going to an agency for a service is somewhat alarming for most people. Asking for help can be frightening. Anxiety is aroused in us in many "first" situations—first dates, first therapist's appointments, seeing a new doctor, a job interview, and so forth. For vulnerable families, using a service may be very anxiety-provoking. Your understanding and support may be the key to their getting what they need. Your support might include making the phone call to set up the first appointment; going along for the first appointment; talking with the family just before or just after the appointment; giving support to their continuation; getting permission to share information and doing so, in their presence, if feasible. Having made a referral, it is important to follow up: call the family to see how they found the experience, to make sure they were seen by the right agency. Many families allow themselves to be shunted to someone else and you may need to advocate for proper service. Call the family after the second appointment to encourage and reinforce their involvement. Perhaps they stopped after one appointment. You may need to go with them again, or you may need to interpret to the referral agency personnel the need for outreach and encouraging support.

Outreach essential

Some agencies, after a few broken appointments, close the case with a notation which reads, "Clients not motivated for help." We need to be sure that vulnerable families are offered sufficient support to activate their motivation, and not leave them stranded in their feelings of being unwelcome in an agency's offices. Continued outreach may be necessary, and you may be the one to do this, or to interpret to another professional the need for this.

Read Resource Paper IV
Conduct discussion

(**Leader:** Have participants read Resource Paper IV on p. 119 of the resource material. Conduct discussion on need for on-going liaison, community interaction, follow-up and appropriate referrals and client advocacy.)

How we affect each other
Feelings may be "catching"
We may reflect client's feelings

People, all of us, have a strange power which is hard to define. We are able to create certain emotional responses in others. Usually this is done quite unconsciously, and our own response to another person is usually experienced as autonomous rather than closely related to that other person's feeling-state. If that sounds confusing, it's because it *is* confusing and complicated to explain. For example, take the case of a person who is angry at having been treated unfairly by, say, a computerized billing system. As this person recounts the infuriating situation to us in gory detail, we are likely to become as angry as our friend. Why? We have not encountered the insult, the experience of feeling helpless and frustrated. We are likely not just to feel empathy with the recounter, but to actually *experience* angry feelings.

We may wish to rescue or to reject

In a similar fashion, people who feel angry at a social institution can make us angry also at that institution and at the family; those who feel helpless to deal with their situation in life can make us feel helpless too. Families where child abuse or neglect have been identified are often ones who feel angry, helpless and isolated. By many subtle ways of relating and communicating, they can create in us similar feelings. Furthermore, they can often make us feel that we are the *only* ones who can understand and help them, or that we do not want to help them.

Feelings can generate distrust among agencies

This feeling of distrust and isolation or of overwhelming responsibility on our part can easily carry over into our interactions and communications (or lack of them) with others involved in attempting to help the family. As a result, it is a common practice for various systems in a community to view each other with suspicion, anger, distrust and so forth; each person having some thought that "I can do it best." As a result, families who often need a multitude of supportive services, coordinated and orchestrated, get fragmented pieces, if any. Liaison and communication among the people working in the various community agencies is an absolute necessity for adequate and appropriate provision of help to vulnerable families.

Community coordination essential

(**Leader:** If you have time, the following OPTIONAL exercise is useful to demonstrate how uncomfortable feelings get activated.)

Optional exercise

Instruct group to close their eyes and imagine that they are in an office and Mrs. Jones is seeing them for the first time. Their job is to help Mrs. Jones. Mrs. Jones sits down and says: (Adopt a slightly helpless tone of voice. Be dramatic.) "I am so glad you have time to see me. You are absolutely my last hope! I can just tell you will be able to help me. I've been to four other places, and they all have waiting lists, or no time, or just were not interested. I am feeling absolutely desperate and I was so relieved when you could see me right away! The others just did not understand me at all; they didn't even take the time to listen to my difficulty; I only need someone to help me sort out the problem and I am sure you can do that. I am grateful that you are spending time with me."

"Helplessness" exercise

Conduct group discussion on how this made people *feel.* Some may try to tell you what they wanted to do. Ask what *feelings* made them want that. Some feelings may be: irritation; helplessness; eagerness to help; anger at other agency personnel; despair. All of these reflect how Mrs. Jones herself is feeling. Go over these feelings of Mrs. Jones in some detail in terms of the interviewer's feelings, reflecting those of Mrs. Jones. Many of the participants' feelings will be related to Mrs. Jones' dependency. You may wish to explore this.

Conduct group discussion

ACTIVITY 10. LEADER PRESENTATION: "Crisis Intervention"

45 minutes

A crisis is a period in a person's life when an apparently insoluble problem presents itself. A situation requiring some action arises, but previous learning has not prepared the individual for this particular set of circumstances. One might say a crisis is a situation in which one just does not know what to do. Within this framework, then, those with better coping skills will have fewer crises. Often, it can be seen that a crisis is in the eye of the beholder. What for one person might be an annoyance for another is a crisis. The Chinese translation of "crisis" is "dangerous opportunity." Clearly, then, a crisis can be seen as a turning point; in drama, after a crisis and its eventual handling, the individual is better off or worse off, but rarely the same. Parad, in the recently published Encyclopedia of Social Work (1977), says:

Crisis described
Crisis is where coping skills fail

In essence, then, the crisis state reflects the perception of and response to an internal or external stress or hazardous event that is experienced by the individual or individuals involved as a threat to such vital goals as life, security, and affectional ties.

Parad's definition of crisis

Sometimes the report of child abuse or neglect to the authorities is in itself a crisis for the family, and the reporter will have the opportunity to utilize that moment to help the family mobilize itself in a healthier fashion. Sometimes having to make a report is a crisis for the reporter and thus a crisis is compounded upon a crisis.

Report of child abuse or neglect precipitates crisis

Leader: Have group read paper on "Crisis Intervention," on p. 120 of resource materials. Conduct discussion from questions or comments on paper.

Resource Paper V
Conduct discussion

Some key issues to highlight might be:

1. The concept of the worker as a "handrail". What does this mean in terms of clients' dependency?
2. Intervention of child protective services as producing a state of crisis.
3. The use of supportive systems in the community to reduce familial stress. What supports do the participants have available in their communities?

Summarize the unit's activities and learning.

Summarize

Ask participants to complete evaluations and hand them in as they leave.

Complete evaluations and hand in

Thank participants for their time, patience and involvement.

303

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ATTENTIVE LISTENING

This is an exercise to practice both listening and how it feels to be listened to. The "talker" talks on an assigned topic.

The "listener":

- listens, and *only* asks questions to clarify something which is unclear,
- shows attention by maintaining eye contact, and
- indicates interest by body posture.

RESOURCE PAPER I

"On Being Self-Aware"

There is no doubt in the minds of those who deal with abused and neglected children that the experiences encountered in this work provoke more intense feelings than other interactions, professional or personal. For that reason, being self-aware has become an important focus in training.

The feeling-provoking aspects of child abuse and neglect are based on:

1. The nature of the problem.
2. The compelling identification with the injured child.
3. The need to identify with and understand abusive or neglectful parents.
4. The use of our childhood experiences as a tool for evaluation.
5. The possibility of making mistakes and the potential price of a mistake.
6. Unconscious sensual responses.
7. Having to confront parents with suspicions of child abuse or neglect.

1. The nature of the problem.

Parents are expected to love and protect their children. When they are destructive, instead of nurturing, their behavior, particularly the observable results of their behavior, provokes anger, disgust, immobilization, denial, fright, and—the summation of these emotions—horror, in the witnesses to their deed.

2. The compelling identification with the injured child.

When we as professionals inevitably identify with the hurt child, our own childhood fears are awakened. We dimly, or not so dimly, recall the helplessness and vulnerability of being a child.

3. The need to identify with and understand abusive or neglectful parents.

Acknowledging parental ambivalence which is *so* visible in child abuse and neglect can make us more acutely aware of the negatives in our own parenting experiences. Such experience includes our relationship to our parents and our children. We may more often recall parental lacks or unfriendliness. If we have children, we are forced to look more closely at our own parenting deficiencies.

4. The use of our childhood experiences as a tool for evaluation.

Use of our own upbringing as a gauge of "good" or "bad," acceptable or unacceptable child care is inevitable, and requires our being aware of what belongs to our personal lives alone, and what has general validity. Having to decide when a lifestyle that is unlike our own is destructive to a child can be a challenge. There are no ready answers that preclude our having to use personal judgment, which requires continual self-evaluation.

5. The possibility of making mistakes and the potential price of a mistake.

Parents often deny responsibility for their child's predicament and evidence is frequently not as clear-cut as we would wish it to be. In severe situations, a child's life may be at stake if we decide to report when the parents are uncooperative and evidence is insufficient to do what is necessary to protect the child against their wishes. It may be equally true that if we don't report, the child's life may be in jeopardy. Our sense of responsibility can be overwhelming at times.

6. Unconscious sensual responses.

More difficult to define, more subtle in its presence, and usually unadmitted or unperceived is our attraction to violence, the vicarious "enjoyment" of the forbidden, the "turn on" of behavior, sexual behavior, that impresses us as revolting.

7. Having to confront parents with suspicions of child abuse or neglect.

a. The social taboo against intervening between parent and child has roots that are deep in the development of our culture.

b. Except in the extreme, the criteria are not clear-cut for what is proper child care. We often feel uncertain about our right to make decisions concerning

306

whose child care is adequate and whose is not.

c. Parents usually react to accusations of child abuse or neglect with anger which they may or may not show. Whether they show their anger or not, we are well aware of it and feel the implicit threat.
d. Parents may have ways that are foreign to us, unacceptable, in fact even repulsive to us—but we are in a situation where we are forced to deal with them in an unhostile, helpful way.

Once we recognize our reactions and the feelings associated with them, we can begin to put them in perspective.

1. Self-awareness should help us to use ourselves more constructively with parents so that we don't clobber them with our anger or attempt to overlook our anger by over-identifying with the parent.
2. Self-awareness should prevent imposing our own value system on people who are too helpless to ward off what is useless to them.
3. Self-awareness should halt or at least slow down exhausting ourselves, and open us to methods of help available to us in our field.

RESOURCE PAPER II
"When Wonder Becomes Suspicion"

Several processes must occur as an observer shifts from wondering about the circumstances surrounding a child's injury or neglect to suspicion that the injuries were inflicted rather than accidental. First, he or she must come to grips with his/her own often subconscious resistance to dealing with the reality in order to consider abuse and neglet as possible explanations. Information needs to be gathered—on behavior and interactions of the parents and the child; on the history of the child's present injuries or neglect situation; on the child's past health history; on the history of the family; and on the child's medical condition. Obviously, the type of information will vary according to the training and experience of the observer. The process of gathering this information effectively presupposes knowledge of appropriate issues to raise and the ability to ask questions in a nonthreatening manner. Next, the collected information must be weighed, and the observer must decide whether there is reason to suspect that the injuries were inflicted.

The following are *indicators* coinciding with the processes described above, which should alert the observer to the possibility of nonaccidental injury. One or more of these factors *may* be present, but the existence of *several* should shift wondering about child abuse and neglect to suspecting it.

APPEARANCE/BEHAVIOR OF CHILD

- Child under three years of age (and especially under six months of age) with "accidental" injuries or ingestion.
- Poor overall hygiene or nutrition.
- Lack of proper clothing (torn, filthy, inappropriate, considering weather; e.g., long sleeves or high necklines in hot weather).
- Injuries present on multiple body surfaces (could be accidental only as result of tumbling falls or automobile accidents).
- Extreme or inappropriate behavior for age of child.
- Crying excessively or very little.
- Showing great fear or none at all of adults.
- Wary of physical contact with an adult; fright when adult approaches; "frozen watchfulness."
- Sudden change in conduct when hospitalized or placed in foster care (e.g., regressive behavior, disruptiveness, shyness).
- Dramatic improvement in development and social relationships when removed from household.
- Plays role of parent, attempting to cater to needs of adults.
- Habitual truancy or lateness for school.
- Early arrival at school with late departure for home.
- Refusal to undress for gym class.
- Evidence of learning disabilities/developmental delays (especially language and fine motor skills that cannot be attributed to specific physical/psychological problems).
- Difficult to manage for physical/behavioral reasons (repeated illnesses, difficult to satisfy, makes heavy demands upon parents).

APPEARANCE/BEHAVIOR OF PARENTS/CARETAKERS

- Defensiveness or hostility when questioned regarding injuries.
- Immaturity.
- Extreme dependency.
- Poor impulse control.
- Low tolerance for frustration.
- Indications of drug or alcohol abuse.
- Apparent psychotic or psychopathic behavior.
- Signs of violent behavior.

ROLE-PLAY I

Role-players: Take a few minutes to read the "script" and think about how you will present yourself.

Task: To tell parents that a report to child protective services will be made and why.

Scene: School or day care center. Mr. and Mrs. Brown have come in at 5:00 PM at teacher's request. No mention to date has been made of the purpose of this interview.

Teacher: You have observed that for the past two months, five-year-old Donna comes to school on Mondays with bruises on various parts of her body, including, this week, her cheek and forehead. You have also observed that she is timid and constrained and not likely to use equipment dangerously or to allow herself rough-and-tumble activities which might result in frequent accidents. She is fearful of close contact with other children, and responds to their aggression with immediate withdrawal and relinquishment of position or toy. With you, she is shy and undemanding and when you ask her how she got hurt, she usually drops her head and turns away. This week, she touched her sore cheek and murmured that she was a bad girl and Daddy spanked her. You have never met the parents, and do not know the family situation, but you are now suspecting child abuse.

Mr. and Mrs. Brown: You have recently moved here so Mr. Brown could take a job in a construction firm. Mr. Brown feels it is important to show his masculinity by a blustering manner. Easily put down, he covers up hurt with aggressive, attacking words. He feels it is important to drink with his buddies and does so every weekend with clockwork regularity.

Mrs. Brown feels nothing she does is right and although she defers to her husband, she is, underneath, angry and resentful that he neglects her and Donna to spend weekends with his friends. Like Donna, she tends to hang her head and mumble if directly confronted or asked a question, fearful that direct or implied criticism is intended. She tends to talk to her husband in a somewhat irritating manner, demanding being the closest she can come to asking for something for herself.

ROLE-PLAY 2

Role-players: Take a few minutes to read the "script" and think about how you will present yourself.

Task: To tell mother that a report to child protective services will be made and why.

Scene: Public health clinic. Mrs. Smith is a black woman who has kept an appointment with the public health nurse after having missed five previous appointments. These had been made to follow up treatment for five-year-old Donna's impetigo. At the last appointment, it had been noted that Donna seemed to be squinting and tipping her head, and an eye exam had been recommended. Two appointments at the eye clinic had been missed by Mrs. Smith.

The *public health nurse* is white and has decided on the basis of the above to refer the family to child protective services because of neglect.

Mrs. Smith is on AFDC, has four other children, and was deserted by Mr. Smith four years ago. You feel defeated, are constantly worried by money problems, and find things are easier if you appease angry authorities. You tend, therefore, to be compliant and agreeable to all demands, but you will do what you think best for your family.

NOTES ON ADOLESCENTS

Adolescents present different problems, mainly because they are seen by adults as being more like adults and therefore more reasonable, but at the same time, they are regarded as still children and therefore to be treated as such. Adolescents often present themselves in the same confused fasion. Often adult-sized, they are frequently uncomfortable in their new bodies; given adult privileges like driving automobiles, they frequently accept the responsibility and at the same time act like irresponsible children and use their privileges in a fashion that is the despair of their parents and teachers.

Even the well-adjusted adolescent presents paradoxes of mood swings, of looking one day like a mature adult, the next like a kindergartener. Children who have been abused and neglected have very negative self-concepts, very low self-esteem, are very unsure of themselves and particularly, they are unsure of their acceptability as people. The defensive shields which they erect to protect this painful inner self varies from straightforward hostility to silent withdrawal and everything in-between, including placating politeness.

In talking with the adolescent about what has happened to him, it is important to be careful to be nonjudgmental, both toward the child and toward the child's parents. Most children both love and feel strong loyalty toward their parents, even parents who appear to us to be cruel or harsh. It is important with the adolescent to remember that behind the sometimes brash exterior is a frightened child, and therefore, never ask the adolescent who may appear with bruises or other signs of abuse: "Well, what did you do this time?" It is of equal importance not to ask "What did your parents do to you this time?"

Word your questions in a nonjudgmental, open-ended way. Avoid questions which can be answered yes or no. Some examples of productive questions or comments include: "Can you tell me what happened?" or "I know that when kids get hurt, there is usually something upsetting going on at home," or "I can see that you are upset and I am interested in hearing about it."

In telling the adolescent of your concern and the requirement that you report his injuries to the proper authorities, try to be as open about it as possible. Explain that you are concerned that family problems seem to be ending in the child getting hurt—being careful not to assign blame. Explain further that when this happens, you would want the family to get some help with the problems, and that the law requires that this be reported to Protective Services. Explain as much as you know about what will happen, but if you don't know, say so. It is upsetting to be expecting one thing and have something else happen. If the adolescent responds with hostility, such as, "You stick your nose in everyone's business," or "You have no right to do that!" or some other angry response, you need to stay focused on your concern for him. It may also be useful to recognize the fear that often underlies this kind of anger. You might then respond in one of the following ways: "You seem upset by what I said," or "You may wonder what will happen next," or "Many people (or kids) feel apprehensive in this situation."

Do not "read minds" or "second-guess" the adolescent. It is more useful to universalize the idea than to attribute it to the child. If you say, "I can see this scares you," or words to that effect, the child may feel overwhelmed and panicked that you could so clearly read his feelings, and may well respond with a hostile "Not me!" or "You're wrong!" By saying that "Many people in this situation feel upset, frightened, angry, etc.," you are universalizing the experience and the person is left free to say either "Maybe *they* are, but *I'm* not," or "Yeah, me too!" In either case, he does not feel you are intruding upon him, getting closer than he can at that moment tolerate.

We are going to practice some of these exchanges now in small role-playing groups.

ROLE-PLAY 3

ROLE PROFILE FOR INTERVIEWING ADOLESCENT BOY

Role-players: Take a few minutes to read the "script" and think about how you will present yourself.

Task: To tell an adolescent that a report to protective services will be made and why.

Scene: Youth Center. Black youth worker has observed, in the shower after basketball, that 13-year-old Peter has fresh welts on his back. Casual inquiry elicited the explanation that Peter's father had used a belt on Peter when Peter was caught smoking.

Interviewer: You are black and your task is to tell Peter, who is white, that you are going to call protective services to report the situation as you consider there is reason to believe there has been abuse.

Peter: You think poorly of yourself; you are convinced that all the bad things that happen are your fault, including the acne you are developing. Your way of handling these feelings is to be defensive and sullen, and you tend to say things like "So what?" "Big deal!" and "What's it to you?" Adults always seem so sure of themselves, and that always makes you feel less sure of yourself and resentful. You wish things could be different, but you are pessimistically convinced that they can never change. You also have a sneaking suspicion that the fighting your parents do so often is because of you and your behavior. You wanted the youth worker's sympathy over the beating your father gave you, but you are frightened at having told.

ROLE-PLAY 4

ROLE PROFILE FOR INTERVIEWING ADOLESCENT GIRL

Role-players: Take a few minutes to read the "script" and think about how you will present yourself.

Task: To tell an adolescent girl that a report to protective services will be made and why.

Scene: Youth Center. White youth worker has observed fresh welts on the back and legs of 14-year-old Susan, who is black. Susan readily told the youth worker that her father had done this because she came in 20 minutes late from a date last night.

Interviewer: Your task is to tell Susan that you are going to call protective services as you think there is reason to believe there has been abuse.

Susan: You are a girl who is uncomfortable with the new changes in your body, and you have a deep conviction that you will become an ugly adult. You are also fearful that adults will reject you or mock you. As a result, you are afraid to talk much lest you be ridiculed. Your response to adults talking to you, therefore, tends to be that of hanging your head, hiding your face behind your hair, or hands, and not talking. You feel that your father's treatment was justified since you disobeyed, but your boyfriend had teased you into being ashamed of having to be home so early and that threw you into a frenzy of indecision.

ROLE-PLAY 5

ROLE PROFILE FOR INTERVIEWING ADOLESCENT GIRL

Role-players: Take a few minutes to read the "script" and think about how you will present yourself.

Task: To interview an adolescent girl to determine whether or not she has been the victim of abuse.

Scene: School. Gym teacher has reported that 14-year-old Kim has fresh welts on back and buttocks.

Interviewer: You are the child protective service worker who has come to school to see Kim to determine whether or not there is child abuse.

Kim: You are uncomfortable with all adults, who never understand you. You alternate between being thoroughly exasperated at their denseness and compliant and polite in order to avoid their wrath. Your unsureness with yourself is hidden behind bravado and an attitude of "I can handle it all myself."

RESOURCE PAPER III
NOTES ON INTERVIEWING IN CHILD PROTECTIVE MATTERS

The child protective interview differs in many respects from those conducted in other settings. First, the initial interview, and many of those held subsequently, result from the initiative of the agency under the mandate of State law rather than of the client. Second, from the client's perspective, the service is imposed and may in fact have damaging consequences, i.e., petition for removal, prosecution for abuse. Third, the interviewer has several different functions which may be unclear and confusing to the client. He or she is visiting to *investigate* a complaint; make a *judgment* about its validity; *assess* the family's willingness to receive help voluntarily; and to *offer* that help where appropriate, or recommend court action.

From the client's perspective, the interviewer's investigative function is most important while the helping roles are usually not understood during the initial phases of the relationship. Hence, though the basic principles of interviewing are applicable to the protective function, many elements must be considered when assessing the responses of interviewees.

Whether you are a child protection worker or other professional, there are three basic rules of interviewing: (a) give the client your full attention; (b) don't jump to any conclusions about what the client believes is happening to him or about what the client has done; and (c) when you do not understand something, ask questions for clarification. While these rules apply to voluntary interviews where the client seeks out the service, they are equally applicable in situations where the service seeks out the client.

In "involuntary" interviews, the interviewer must allow for the client's tension and suspicion about the nature of the interview and permit this to be expressed. However, with sensitive questioning, many people, when given the opportunity to talk about themselves, will respond. Consequently, the first interactions often should be addressed to helping the client express concern about the interviewer and the agency; and to help the interviewer understand whether or not the client perceives a problem in family relationships or in child-rearing practices. Where the client does not perceive any problem initially—except for the interviewer's intrusion and the lack of understanding of those who are making the report, the goal of the helping process itself becomes focused on working with the family to accept the existence of a problem where one exists. Often, families will express their own concerns in the course of the interview, indicating not only that they experience problems, but also that they are prepared to allow the interviewer to help.

Obviously, this help cannot be accomplished in one interview. Angry or hostile clients, or individuals who are anxious and severely threatened, are likely to be unable to correctly interpret the interviewer's statements or intentions. Hence, these may bear repetition over several visits if the interviewer is in a position to offer family help, until the anger or anxiety has decreased and the client is more relaxed. It should be apparent that the expression of anger or the existence of anxiety are not, in themselves, indicators of abuse or neglect. Many families may react dramatically to the intrusion of an official agency into their private lives.

Despite the difficulty of making contact and establishing rapport with protective clients, the first step for the interviewer is to attempt to establish an understanding with the client about the focus of the relationship. For a child protective worker, this is often described as establishing a contract. It is a necessary precondition to any helping relationship. The interviewer can assist the individual to enter into a relationship by being supportive, reassuring and indicating sympathy for the client's problems and respect for the client as an individual. While there is no need to apologize for a protective involvement, the interviewer should always be sensitive to the client's perception of the meaning of the interview. Since many protective clients have had negative experiences with public agencies, and feel themselves powerless before large organizations, it is to be expected that they will often react either passively or with anger to child protective workers and to anyone who is reporting them. Understanding the feelings of powerlessness of many protective clients is an important step in building a working relationship. When a client is able to ask for help and discuss family problems, it is usually an indication that the interviewer has successfully conveyed a sense of concern and respect for the client, and has been able to earn the client's trust. This is a difficult task when the client willingly seeks service; it is even more problematic when the service is initiated by official agencies.

BIAS SIMULATION GAME

INSTRUCTIONS TO LEADER

There are eight participants. Number off your trainees in any order so that there are eight people assigned to each game group, each with a number from one to eight. It does not matter what color or sex the participants are. That is, it is all right for a white female to be assigned to role-play a black male. The number they are given determines which role they play.

Participants should be asked to read the Introduction and Task, or you can read it aloud to them.

Assign 10–20 people to each committee group. Eight will be players and the rest will be observers. Ask each player to read his or her profile *only* and to write on a large piece of paper the sex, color, and any ethnic information, and tape this to their clothing in a prominent fashion, e.g., WHITE JEWISH FEMALE.

The observers should be asked *not* to read any profiles, but to sit around the committee on the outside of the group and make notes about what they observe regarding any kind of bias at all.

After the meeting is over (30 minutes), reconvene the entire group and discuss the following:

1. Did the task get accomplished?
2. What factors facilitated or interfered with the accomplishment?
3. What were some of the feelings encountered?
4. What did the group feel they learned from the exercise?

BIAS SIMULATION GAME

INTRODUCTION

This game has two objectives: (a) to help participants become more aware of their own latent cultural, class, racial, ethnic or sex biases; (b) to accomplish the task.

Task

A philanthropist in your community has offered to give $75,000 for a children's free recreation program for this coming summer. The stipulation is that it must offer something for all the children in the community and a coordinated plan must be in the philanthropist's hands before the end of March, or the money will not be forthcoming.

Today's date is March 20, and this committee, representing different groups, is having one final meeting in an attempt to formulate a comprehensive plan. You have 30 minutes for this task.

1. CHAIRPERSON

Coordinator for Youth Services (county or city government).

You are a white, middle class male with a B.A. in English Literature. After working as a Probation Officer for two years, you were appointed to this position by the mayor, an elected city official. Your family has known his family for many years, and he has told you that a plan must be devised. Two months ago, a youth was stabbed by some friends in a tragic accident in an affluent suburb. These parents, all wealthy, have been putting pressure on the mayor to "do something." The mayor expects you will help him. You have a deep-seated dislike and distrust of all professionals with degrees above a B.A.

2. YMCA YOUTH WORKER

You are a black female social worker with an MSW. You have been working with inner city, deprived youth, putting together meaningful programs on a shoestring budget. Most of your clients are children of single-parent welfare recipients, and you see this money as an opportunity to provide programs for these children that will get them out of the slums and let them experience another way of life. You feel that children from the affluent suburbs should be able to pay for their own summer recreational programs.

3. JUVENILE OFFICER, POLICE DEPARTMENT

You are a white older male, and you see shoplifting and vandalism as the primary problems in the community. Mostly, you think, this is committed by black youth, and you know that they have different moral values from yours. You want a program to get these black youth off the streets for the summer, and you refer to them as the "colored kids." You are not unkind about them or their problems, but you see them as very different from you and your problems.

4. PEDIATRICIAN FROM THE HEALTH DEPARTMENT

You are an Hispanic-American female physician and feel your position as a minority female keenly. People always act surprised that you are a doctor, and you have come to expect condecension and to anticipate it. Consequently, you tend to act in a pushy, aggressive fashion, insisting on your point of view, and using medical jargon to "snow" any opposition. You work with poor, mostly black or Spanish-speaking families, and want these children to have a special program for the summer. You see nutrition and fresh air as the most important components.

5. HEAD START TEACHER.

You are a white Jewish female who has experienced some anti-Semitism. You are sensitive to this and always wonder, if people do not accept your ideas, if it is because you are Jewish that they are rejected. As a Head Start teacher, you feel that the best summer program for all ages of children is to increase their academic skills so they can use education to get ahead in the world.

6. SCHOOL SOCIAL WORKER.

You are a black male, and feel that what the youth of the community need are programs which will develop skills for youth to use in the job market. Most of your concerns are with black, inner city youth who will not be going to college and who are not learning employable skills.

7. SOCIAL WORKER FROM CHILD GUIDANCE CLINIC.

You are a white female MSW of Polish background. Coming from a poor family, you worked your way through college and graduate school and you feel that anyone with "motivation" and drive can do the same. You chose to work in a psychiatric setting, because of the status, and because its client population is middle to upper class. Your need to reject your origins make you supersensitive to ethnic comments, and as you want to progress up the administrative ladder, you are equally keen to make sure no one makes sex a barrier. You tend to use your knowledge of human behavior to put others down. Your ideas for the summer program are to provide opportunities for your middle-class emotionally-disturbed children to be away from their families.

8. ADMINISTRATOR FROM RECREATION DEPARTMENT.

You are a black male with a master's degree in business administration. You come from a professional family where men made all the decisions, and women had a decidedly subordinate position. You are aware that you are biased against professional women, and try consciously to correct that, not always successfully. You do not care how the money is spent as long as an acceptable plan to spend it is made. You would like your department to handle the money and funnel it however the committee decides.

9. GROUP HOME SOCIAL WORKER

(Leader: The following are roles which are optional either to add to the previous eight, or to substitute for some of the roles delineated. In areas of the country where there are Native Americans, it would be useful to include these roles.)

You are a Native American Indian male. You have come from a poor, broken family and as a young boy had problems with alcohol and drugs. Your family was prejudiced against whites as well as against other Indian tribes. You have been trying, as you worked your way through college and graduate school, to overcome these prejudices and be a bridge between these cultures. You now see your mission as helping your Indian brothers and sisters who are struggling with the same problems you had, as well as helping the children in the group homes to lead happier lives. Since you are fearful that people will think you are a "dumb Indian," you therefore think carefully before you speak.

10. SCHOOL BOARD MEMBER.

You are a Native American Indian female. You came from a large family and have four children of your own. You live in this community and are a member of the school board. Going to school part-time, you finally got a bachelor of education degree and teach in the high school on the reservation. Your main concern is helping Indian children stay in school and out of trouble. Since you see prejudice as one of the main problems between whites and Indian students, you try to present the Indian point of view so the children will be better understood by the white community. Since you are always sure that you will be perceived as a "dumb Indian," you think carefully before you speak.

RESOURCE PAPER IV
MAINTAINING CONTACTS IN THE COMMUNITY

The average person is surprised to discover the number of community agencies which deal with some aspect or another of child abuse and neglect. It is of prime importance to become familiar with the activities and philosophy of those professionals who do become involved. It is especially vital to maintain contacts *before* a crisis arises in order that those in trouble can be handled with the care and nurturing they will need in the event of a crisis. This would at least reduce the probability of further trauma to the individual and aid in the sensitivity with which the situation is handled. It is essential for adequate provision of help to families to be knowledgeable about community resources. The chain of services to those parents who may be abusing or neglecting is very important in terms of prevention as well as crisis intervention.

It is becoming more apparent to those who are in the human services field that we must become more familiar with each other's roles in dealing with people. It is only through an understanding and acceptance of the various roles that we can band together to form linkages necessary to prevent the breakdown of services provided, in order to complement one another's roles and to close the gaps in the line of service.

The following professionals may become involved with child abuse and neglect situations:

- Police officers or sheriffs
- Mental health professionals
- Child protective services workers
- Doctors, nurses, emergency hospital staff
- School counselors, social workers, psychologists
- Family court personnel
- Lawyers
- Day care center staff
- Neighborhood center workers
- Clergy
- Drug and alcohol center counselors
- Private social agency staff
- Juvenile probation officers
- Self-help groups
- Nontraditional services

Some of the steps in maintaining community contacts are:

I. Being alert to agencies *already* involved in the well-being of the child.
   a. When you know a particular agency is involved with a child, keep in touch by phone.
   b. Ask for joint meetings between your professional people and those in the other agency for on-going help to the child and family.

II. Meeting the *people* who work in those agencies on neutral ground so that when a crisis arises, there has already been some mutual trust development.

III. Utilizing community resources in your immediate neighborhoods on a common needs basis:
   - Crisis availability
   - Summer recreation
   - Socialization skills
   - Adult education
   - Community awareness
   - Health care services

IV. Bringing together groups of community people who have the same cases in common. For example, interdisciplinary teams, traditional case conferences, interagency staffings.

V. Having an *Agency Day* either in the schools or neighborhood center where each agency unit and the public can become familiar with the services, and get to know one another as people.

VI. Inviting parents to come together around the topic of child development and child-rearing practice.

VII. Schools and neighborhood centers working together on recreational pursuits for both children and adults.

RESOURCE PAPER V
CRISIS INTERVENTION AS A TREATMENT STRATEGY IN CHILD ABUSE AND NEGLECT PROGRAMS

Professional workers dealing with the early phases of child abuse and neglect cases are confronted consistently with families in a crisis state. There appears to be a continuum of families, ranging from those who are numbed by the course of events to those who respond with overt hostility and anger. Professional workers also have their own crisis states to deal with in terms of their reactions to the abuse and/or neglect incident and the parental behaviors exhibited. In fact, the high turnover of professional workers in child abuse and neglect programs is often related to "burn-out"—as a result of the pressures of working with families in crisis.[1]

Professionals interested in engaging abusive or neglectful families in the helping process need to understand the dynamics of the crisis period as it has impact upon parents and children as well as upon themselves. When an understanding has been gained, specific crisis intervention skills need to be incorporated. It is also important to consider the structure of providing services in order that effective crisis intervention approaches can be facilitated.

Applying Crisis Theory to Child Abuse and Neglect Cases

In an attempt to differentiate among various types of crises, Reuben Hill developed three major categories: dismemberment (death, separation, etc.), accession (unwanted pregnancy, adoption, etc.), and demoralization (delinquency, infidelity, arrest, etc.). In pointing out crises that involved demoralization, with dismemberment, or accession, he included imprisonment and institutionalization for mental illness.[2] The processes of mandated reporting and investigations of child abuse and neglect, with their potential sanctions of arrest under criminal statutes and/or removal of children under civil statutes, can coalesce to present the families with a crisis that has both demoralization and dismemberment aspects. This suggests that most families are undergoing a serious situational crisis at the initiation of intervention.

Incidents of physical abuse or severe neglect are in themselves crisis events. For purposes of this discussion, however, they will be considered precipitating events, leading to contact with the family and the actual investigation crisis. Since one of the characteristics of crisis intervention treatment is to focus on the presenting problem, the emphasis will be placed on the situational crisis that develops as a result of the report and investigation and its precipitating event(s).

The abusive or neglectful family, in experiencing a situational crisis, undergoes a predictable series of reactions: (next page) Families differ in the kind of response they have to such situational crises as abuse or neglect and its subsequent investigation. Specifically, the nature of the disorganization and the time needed for recovery to a new state of equilibrium may vary. The state of reorganization may be at a more or less satisfactory level compared with the prior level of functioning, depending on how successfully the family handles and responds to the crisis.

In a state of crisis, the psychological equilibrium of the family is disturbed. During this period of upset, the family is more susceptible to influence by others than at times of relative psychological equilibrium. Some suggest that psychological defenses are lowered for a short time. Crisis theorists maintain that deploying helpful services to families in crisis requires a small amount of effort and yields a maximum amount of response.[4] In short, abusive or neglectful fami-

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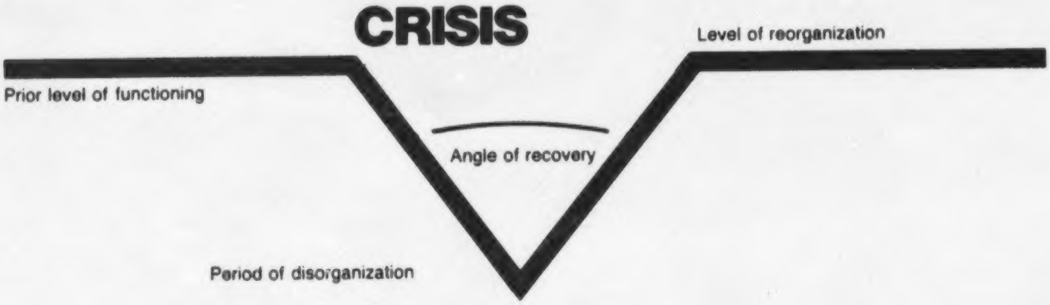
[1] Ann Cohn, "Summary of Findings to Date: Evaluation of the Joint OCD/SRS Demonstration Program in Child Abuse and Neglect" (Berkeley, CA: Berkeley Planning Associates, November, 1976), mimeo, p. 22–23.

[2] Reuben Hill, "Generic Features of Families Under Stress," in Howard Parad (ed.), *Crisis Intervention: Selected Readings* (N.Y.: Family Service Association, 1975).

[3] *Ibid.*, p. 45.

[4] Erich Lindemann, "Symptomatology and Management of Acute Grief," *American Journal of Psychiatry*, Vol. 101 (September 1944); Gerald Caplan, *Prevention of Mental Disorders in Children* (New York: Basic Books, 1961), p. 13; Lydia Rapoport. "The State of Crisis: Some Theoretical Considerations," *The Social Service Review*, Vol. 36 (1962).



(Hill, 1965, p. 45)[3]

lies are potentially most prone to accepting help while in this state of disequilibrium.

Engaging abusive or neglectful families in treatment needs to be an immediate response for a number of reasons:

(1) Dynamics associated (with the abuse or neglect situation) are more easily accessible if they are recent.
(2) Only active conflicts are amenable to therapeutic intervention.
(3) Disequilibriated states are more easily resolved before they are crystallized. (Lukton, 1974, p. 392)[5]

Theory suggests that the beneficial effects of the crisis diminish with time. However, this emphasis on early intervention does not detract from the need for on-going treatment, which is a part of the range of services of child protective programs. Their short-term and long-term goals can be enhanced by skillful and timely handling of the crisis aspects of the initial intervention.

Initial contact should occur within twenty-four hours of the report. Where possible, the professional making initial contact should be able to continue with the family through subsequent stages. The handling of the immediate crisis event is but the first step in helping the family work through the crisis and the disequilibrium that results. Failure to follow through may defeat the initial opening up of the helping process.

Recognizing the need for continuity of care, some programs have all direct services staff rotating through intake to pick up and continue with new cases. This allows staff to experience some resolution of problems as well as confronting difficult problems that dominate earlier contacts. Some programs, recognizing the special demands placed on crisis intervention staff, deliberately use half-time professionals. In other instances, workers are restricted to one new child abuse or child neglect case per week. Those child protective programs in which workers are constantly confronted with the crisis management that accompanies intake usually have serious problems of worker burn-out and difficulty in achieving positive results.

Whatever the way the service program is organized, there are important supports that workers must have in order to handle the crisis aspects of child abuse and neglect cases effectively. An important ingredient is the support given workers by effective supervision. Workers must feel free with their supervisors and colleagues to ventilate and deal with the intense feelings created by working with abusive and neglectful families. If these feelings are not expressed, important sensitivities essential to the helping process can be dulled. The hurt and pain that dominate the lives of abusive or neglectful families cannot help but have an impact on the involved professionals. In the process of investigating cases, there is often a strong

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[5] Rosemary C. Lukton, "Crisis Theory: Review and Critique," *Social Service Review*, Vol. 49 (September 1974), p. 392.

331

reaction to the harm done to the child. Workers need to anticipate these reactions and important agency supports need to be operative. These natural human reactions emerge from the same source within the personality that enables the worker to respond sensitively to clients, whether children or parents. Repression or denial reactions may take a serious toll in terms of treatment effectiveness.

An important aspect of professional/client interaction is the approach taken to the inherent conflict that is part of initial contacts. "The crisis has a chaotic effect, family coping mechanisms are severely taxed and a sense of helplessness ensues . . . ."[6] Often, this response to loss of control over critical events affecting the family will elicit angry, hostile feelings toward the professional. What has to be remembered is that the child protective services worker or other helping professional is not without resources. Some writers in the field (Justice and Justice;[7] Helfer and Kempe[8]) recommend a separation between authority and the treatment process. In the crisis intervention stage, however, the phenomenon of power (or authority) can have a stabilizing impact on those who are experiencing a sudden arbitrary and unanticipated crisis. Families in these situations often want an objective, skillful, benign authority who can successfully negotiate, indicate, or arbitrate a constructive outcome to the crisis.[9]

The issue tends to be not how to eliminate or prevent conflict, but rather "how to make it productive, or at least, to prevent it from becoming destructive" (Deutsch, 1971, p. 42)[10]. Some workers tend to thrive on crisis-oriented work and feel challenged (rather than threatened) by the hostile, angry client. At a minimum, professional staff need to feel comfortable in dealing with client hostility. If conflict is inevitable, it also needs to be seen as presenting opportunities for working with abusive and neglectful families. Conflict management skills can convert an attack into a focusing of important energies on the problems which precipitated the crisis.

Differentiating Family Responses to Crisis

Although there is a predictable crisis in most child abuse and neglect cases, individual families may respond quite differently. The family's attitudes toward the incident and the subsequent investigation are important, as is the extent to which families perceive the intervention as a crisis. Abusive and neglectful families, typically, are isolated from their social environment. In response to the crisis, some families will withdraw from all activities "until the shame is over," becoming more than ever a closed system.[11] It is important for the worker to identify the usual symptoms of a family's crisis state. They include the following:

- Parent(s) denying child maltreatment, despite strong evidence to the contrary.
- Parent(s) projecting responsibility for the incident onto the child, a bad environment, or the other parent.
- Parent(s) seeing the investigation and possible legal action as an unwarranted intrusion into their lives.[12]

In short, some families meet a crisis with strength and resourcefulness; others meet it with ineffective, self-defeating coping efforts.[13]

In some cases, parents appear to perceive the reality of the child's condition, show capacity to discuss their own responsibility, and express willingness to participate in a constructive action plan to prevent future abuse or neglect. In these instances, the family's coping mechanisms are functioning. Parents who demonstrate this type of adaptive behavior may have minimal negative reactions to the crisis. It is important, therefore, to distinguish between those abusive or neglectful families for whom the situation results in a crisis state and those for whom it does not.

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[6] Morton Bard, *Family Crisis Intervention: From Concept to Implementation* (Washington, D.C.: LEAA-National Institute of Law Enforcement and Criminal Justice, December 1973), p. 3.

[7] Blair Justice and Rita Justice, *The Abusing Family* (N.Y.: Human Sciences Press, 1976).

[8] Ray E. Helfer and C. Henry Kempe (eds.), *Child Abuse and Neglect: The Family and the Community* (Cambridge, Massachusetts: Ballinger Publishing Co., 1976).

[9] Morton Bard, *op.cit.* p. 3.

[10] Martin Deutsch, "Toward an Understanding of Conflict," *International Journal of Group Tensions*, Vol. 1 (1971), p. 42.

[11] Reuben Hill, *op.cit.*, p. 45,

[12] Adapted from crisis intervention techniques used with parents of delinquent youth (including status offenders). See Jacob I. Hurwitz, David M. Kaplan, and Elizabeth Kaiser, "Designing an Instrument to Assess Parental Coping Mechanisms," in Howard Parad (ed.), *Crisis Intervention* (N.Y.: Family Service Association of America, 1965), p. 343.

[13] H. Frederick Brown, Vera Barad Burditt, and Charles Liddell, "The Crisis of Relocation," in Howard Parad (ed.), *op.cit.*, p. 259.

Model for Crisis Intervention

The crisis literature has consistently identified specific areas for focusing the professional intervention. Lydia Rapoport's model of crisis intervention[14] has been adapted for use in child abuse and neglect cases:

1. Keep an explicit focus on the crisis.
   - Help the family gain a conscious grasp of the crisis in order to enhance problem-solving.
   - Clarify the precipitating abuse or neglect event and its relation to personal stress.
2. Help parent(s) with the feelings surrounding the situation.
3. If temporary placement of the child is required, help parents and child to deal with separation-anxiety.
4. Provide factual information about the process that will be followed, including the ways in which the worker will be of assistance and what other agencies will be involved.
5. Create a bridge to community resources and specific services that can be provided to stabilize the family situation.

These steps provide general guidelines for worker activities with the individual family. These five kinds of concerns are not sequential, but need to occur at various intervals and will need to be reinforced again and again.

The Worker as Handrail

A child abuse or neglect case often involves a variety of agencies, professionals, and procedures that can be baffling to any family, but particularly difficult for those involved in child abuse and neglect. As pointed out earlier, these families' coping mechanisms are often not functioning well. The professional who becomes the primary helper with a given family needs to be supportive as the family moves through the various legal and agency procedures. Care must be taken to explain the various steps required and what resources are available. Equally important is assisting the family with such concrete tasks as arranging transportation and advocating with other agencies for such concrete services as emergency food or shelter.

The primary helper needs to have the capability of providing the appropriate emergency in-home services to help stabilize the home situation. Following the Comprehensive Emergency Services program demonstrated in Nashville, Tennessee,[15] several states are adopting statutes that provide for emergency caretakers who can be placed in the home for brief periods. Creative use of homemakers or parental stress volunteers is another important way to begin relieving some of the environmental stresses.

The professional who is the primary helper serves as a "handrail" for these families as they move through the various procedures.[16] The families begin to perceive this professional as a helping person, one they can trust as they begin to sort out their problems. Although the professional may be the primary helper, he/she should also be aware that "a person or family in crisis becomes more susceptible to the influence of significant others in the environment." (Tyhurst, 1958, p. 25)[17] The worker needs to identify others in the environment who can be encouraged to provide support. Again, social isolation of abusive or neglectful families occurs almost without exception. This crisis period is a time when that isolation can be lessened by providing links to supportive services and relationships with others. ". . . The helping person needs to view himself as intervening in a social system—as a part of a network of relationships—and not as a single resource."[18] The worker needs to be aware that he/she doesn't have to do everything.

In the early stages of working with abusive and neglectful families, the primary helper has an excellent opportunity to view adaptive and defensive structures that may not be apparent after the crisis. By focusing on the presenting situation, and the fact that the situation has come to the attention of an agency, the healing process can be enhanced. The worker who is able to deal effectively with initial anger and hostility can be a critical factor in seeing that the parent accepts help and that the children are given the protection they need.

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[14] Lydia Rapoport, *op.cit.*, p. 329. Also see Gerald Caplan, "Pattern of Parental Response to Crisis of Premature Birth," *Psychiatry*, Vol. 23 (1960), pp. 365–374.

[15] Marvin Burt and Louis H. Blair, *Options for Improving the Care of Neglected and Abused Children* (Washington, D.C.: The Urban Institute, 1971).

[16] Brown, Burdett, and Liddell, *op.cit.*, p. 251.

[17] James S. Tyhurst, as quoted by Lydia Rapoport, *op.cit.*, p. 30.

[18] Lydia Rapoport, *op.cit.*, p. 30.

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